

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
PD-45 (rev. 4), “WORKERS’ COMPENSATION AND RETURN TO WORK PROGRAM”
SEPTEMBER 1, 2015

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TEXAS DEPARTMENT
OF
CRIMINAL JUSTICE

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March 1, 2004

EXECUTIVE DIRECTIVE

SUBJECT: WORKERS' COMPENSATION AND RETURN TO WORK PROGRAM

AUTHORITY: Tex. Gov't Code §§ 493.001, 493.006(b); Tex. Lab. Code §§ 501.001-.051; Tex. Health & Safety Code §§ 81.003(1), 85.116; 25 Tex. Admin. Code §§ 96.101 (Dept. of State Health Services, Definitions), 97.13 (Dept. of State Health Services, Death of a Person with Certain Communicable Diseases); 28 Tex. Admin. Code §§ 45.10 (Tex. Dept. of Insurance, Div. of Workers' Compensation, Employer's Report of Injury and Disease), 109.1 (Tex. Dept. of Insurance, Div. of Workers' Compensation, State Agencies: General Provisions), 122.3 (Tex. Dept. of Insurance, Div. of Workers' Compensation, Exposure to Communicable Diseases; Reporting and Testing Requirements for Emergency Responders), 251.207 (State Office of Risk Management, Requirements for Submitting Form TWCC-1S); Tex. Educ. Code § 19.009(g); State Office of Risk Management, "Risk Management for Texas State Agencies"; Correctional Managed Health Care Policy B-14.5

Reference: American Correctional Association Standard 4-4041

APPLICABILITY: Texas Department of Criminal Justice (TDCJ)

EMPLOYMENT AT WILL CLAUSE:

These guidelines **do not** constitute an employment contract or a guarantee of continued employment. The TDCJ reserves the right to change the provisions of these guidelines at any time.

Nothing in these guidelines and procedures limits the executive director's authority to establish or revise human resources policy. These guidelines and procedures are adopted to guide the internal operations of the TDCJ and **do not** create any legally enforceable interest or limit the executive director's, deputy executive director's, or division directors' authority to terminate an employee at will.

POLICY:

The TDCJ shall administer a Workers' Compensation and Return to Work Program in a fair and consistent manner in compliance with the *Texas Workers' Compensation Act* and without regard to race, color, religion, sex (gender), national origin, age, disability, genetic information, or uniformed services status. The TDCJ has zero tolerance for all forms of employment discrimination. No employee or other individual shall be subjected to harassment or retaliation for opposing or reporting employment discrimination in the Workers' Compensation and Return to Work Program.

DEFINITIONS:

"As Soon As Practicable" is as soon as possible and practical, taking into account all of the facts and circumstances in the individual case.

"Business Hours" are 8:00 a.m. - 5:00 p.m., Monday through Friday.

"Common Use Area" is an area in a unit or department accessible to all employees assigned to the unit or department during each shift, such as the break room or lobby area.

"Communicable Disease" is an illness occurring through the transmission of an infectious agent or its toxic products from a reservoir to a susceptible host, either directly as from an infected person or animal, or indirectly through an intermediate plant or animal host, a vector, or the inanimate environment. Examples of communicable diseases include hepatitis B, human immunodeficiency virus (HIV), and tuberculosis (TB).

"Compensable Injury" is a work-related injury for which compensation is payable under the *Texas Workers' Compensation Act*.

"Disability," for the purpose of this directive, is the inability, because of a compensable injury, to obtain and retain employment at wages equivalent to the pre-injury wage. "Disability" under state workers' compensation law is defined differently than "disability" under the *Americans with Disabilities Act* (ADA), because the state workers' compensation law serves a different purpose.

"Employee" is any person employed by the TDCJ in a full-time, minimum 40 hours per week, or part-time, minimum 20 hours per week, position on a non-contract or non-temporary basis.

"Exposure" is specific eye, mouth, other mucous membrane, non-intact skin, or needle contact with blood or other potentially infectious materials resulting from the performance of an employee's duties.

"Health Care" includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services, but does not include vocational rehabilitation. Health care also includes: (1) medical, surgical, chiropractic, podiatric, optometric, dental, nursing, and physical therapy services provided by or at the direction of a

doctor; (2) physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of a doctor; (3) psychological services prescribed by a doctor; (4) the services of a hospital or other health care facility; (5) a prescription drug, medicine, or other remedy; and (6) a medical or surgical supply, appliance, brace, artificial member, or prosthesis, including training in the use of the appliance, brace, member, or prosthesis.

“Health Care Provider” is a doctor of medicine or osteopathy, podiatrist, dentist, clinical psychologist, optometrist, chiropractor, licensed acupuncturist, nurse practitioner, nurse midwife, or clinical social worker who is performing within the scope of their practice as defined under state law, any health care provider recognized under the Texas Employees Group Benefits Program, or a Christian Science practitioner listed with the First Church of Christ, Scientist in Boston, Massachusetts.

“Health Care Provider’s Statement” (HCPS) is a written statement from an attending health care provider identifying the medical fact(s) associated with the injury or illness and the expected duration of the injury or illness. It is possible for a written statement from the employee’s attending health care provider to meet the requirements to be considered both an HCPS and a release to return to work. However, an HCPS does not automatically meet the requirements to be a release to return to work.

“Job Description” is a TDCJ document defining the job summary, essential functions, minimum qualifications (education, experience, knowledge, and skills), and additional requirements with or without reasonable accommodations in reference to a specific position within the TDCJ. The “Additional Requirements With or Without Reasonable Accommodation” section identifies the physical and mental characteristics necessary to perform the essential functions of that position, the job location, special conditions, and equipment used in performing the essential functions.

“Medical Fact” is a description of a condition that identifies the cause or nature of the injury or illness, such as viral illness, internal bleeding, back pain, or upper respiratory infection. A procedure that identifies the body part, such as hysterectomy, appendectomy, or tonsillectomy is sufficient information to serve as a “medical fact.” Terms such as “under my care,” “surgery,” or “stress” are not acceptable as medical fact. A medical fact does not require a diagnosis.

“Occupational Disease” is a disease arising out of and in the course of employment causing damage or harm to the physical structure of the body, including a repetitive trauma injury. The term includes a disease or infection naturally resulting from the work-related disease. The term does not include an ordinary disease of life to which the general public is exposed outside of employment, unless that disease is incident to a compensable injury or occupational disease.

“Release to Return to Work” is a written statement from an employee’s attending health care provider that identifies a date the employee may return to work and clearly indicates: (a) restrictions or limitations and whether they are of a temporary or permanent nature; or (b) no restrictions or limitations. Any statement without reference to restrictions or limitations shall be considered an unconditional release. It is possible for a written statement from the employee’s attending health care provider to meet the requirements to be considered both a release to return

to work and an HCPS. However, a release to return to work does not automatically meet the requirements to be an HCPS. A release to return to work for an employee who has been absent due to a work-related injury or illness may consist of a DWC FORM-73, Texas Workers' Compensation Work Status Report.

"Temporary Duty Assignment" is a temporary alternate duty assignment or a temporary modified duty assignment. A temporary duty assignment shall be for a maximum period of 12 consecutive workweeks per work-related injury or illness, even if the employee works intermittently during the assignment. A temporary duty assignment allows an eligible employee to perform duties and tasks within the temporary physical or mental limitation(s) established by the employee's health care provider and shall only include duties considered non-correctional duties. The employee's rate of pay shall be the same rate the employee was receiving at the time the work-related injury or illness was sustained or incurred.

- (1) "Temporary Alternate Duty Assignment" refers to duties assigned through the Return to Work Program to a correctional employee who incurred a work-related injury or illness. During the assignment, the employee shall dress in attire appropriate for a non-correctional employee and have a schedule the same as a non-correctional employee.
- (2) "Temporary Modified Duty Assignment" refers to duties assigned through the Return to Work Program to a non-correctional employee who incurred a work-related injury or illness.

"Work-Related Injury or Illness" is damage or harm to the physical structure of the body arising out of and in the course of employment. The term includes an occupational disease.

"Workday," for the purpose of this directive, means a day when an employee is normally scheduled to work.

"Workers' Compensation Program Area" is the program area within the Human Resources Division responsible for: (1) coordinating the processing of all Workers' Compensation transactions through the State Office of Risk Management (SORM) within a specified time frame; (2) providing technical assistance to TDCJ staff; and (3) reporting statistical information.

"Workweek," for the purpose of this directive, is a period of seven consecutive calendar days with the beginning of the workweek being on the same calendar day the temporary alternate or modified duty assignment is scheduled to begin. For example: If a temporary alternate or modified duty assignment is scheduled to begin on a Wednesday, the period from Wednesday through Tuesday counts as one workweek of the assignment.

DISCUSSION:

An employee who fails to comply with the procedures within this directive, unless it is not practicable under the particular circumstances to do so despite the employee's diligent, good faith efforts, may be subject to disciplinary action in accordance with PD-22, "General Rules of Conduct and Disciplinary Action Guidelines for Employees," or administrative separation in accordance with PD-24, "Administrative Separation."

I. Medical Attention and Health Care

A. Initial Medical Attention from Unit Medical Staff

Unit medical staff may provide necessary medical attention, including initial evaluation and treatment, to a TDCJ employee who is injured or contracts an illness in the performance of the employee's duties. Unit medical staff shall not provide follow-up evaluations and treatment of work-related injuries or illness nor routine medical services for non-work-related injuries or illness.

B. Health Care

1. The *Texas Workers' Compensation Act* currently provides that an employee who sustains a compensable injury or illness is entitled to all health care required by the nature of the injury or illness as and when needed. This may include health care that:
 - a. Cures or relieves effects naturally resulting from the compensable injury or illness;
 - b. Promotes recovery; or
 - c. Enhances the ability of the employee to return to or retain employment.
2. Except in an emergency, all health care shall be approved or recommended by the employee's attending doctor.

II. Reports of Work-Related Injuries or Illnesses

- A. An employee who has sustained or incurred a work-related injury or illness shall not be subjected to retaliation for filing a claim for workers' compensation benefits in good faith or for exercising any other rights provided by the *Texas Workers' Compensation Act*.

- B. All reports of work-related injuries or illnesses allegedly sustained in the course and scope of employment shall be completed and distributed as outlined in this directive.
- C. A work-related injury or illness becomes reportable when one of the following occurs:
 - 1. The employee affected by the work-related injury or illness has been absent from work for at least one full scheduled work shift;
 - 2. Medical expenses have been incurred;
 - 3. The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) requests a report;
 - 4. A work-related fatality occurs and the injury or illness was not self-inflicted;
 - 5. The employee claims to have contracted a contagious or infectious disease due to a work-related exposure; or
 - 6. The employee has an occupational disease the TDCJ knows about, even if the employee has not missed any work.
- D. All records related to an employee's medical condition are confidential under state and federal statutes and shall be protected accordingly.

III. Workers' Compensation Benefits

- A. The SORM determines if an employee is eligible to receive workers' compensation benefits.
- B. Benefits are governed by state law and administered by the TDI-DWC. Compensation payments are set at the rate specified by law on the date of injury or illness.
- C. The SORM may reduce the employee's temporary income benefits, if an employee rejects a bona fide offer of a temporary alternate or modified duty assignment through the Return to Work Program that the employee is reasonably capable of performing, given the physical condition of the employee and the geographic accessibility of the position to the employee.
- D. As directed by statute, benefits are provided to the appropriate beneficiaries upon an employee's death resulting from a work-related injury or illness.

IV. Return to Work Program

A. Participation Requirements

An employee who has sustained or incurred a work-related injury or illness shall participate in the Return to Work Program in accordance with this directive.

B. Employee with a Disability

An employee's participation in the Return to Work Program shall not be construed as recognition by the TDCJ that the employee has a disability as defined by the ADA and does not constitute an accommodation under the ADA.

C. Other Temporary Assignments

Temporary alternate or modified duty assignments in accordance with this directive do not remove an employee from the employee's job position, and shall not count toward the six months an employee may be temporarily assigned to another position in accordance with PD-93, "Employee Classification."

V. Fraud

A. An employee who commits fraud by making a false or misleading material statement, misrepresenting or concealing a material fact, fabricating, altering, concealing, or destroying a document, or conspiring to do these acts may be subject to administrative or criminal penalties.

B. Individuals with knowledge of suspected workers' compensation fraud may provide a signed written report regarding such information to the Workers' Compensation Program Area for submission to SORM. The Workers' Compensation Program Area shall provide a copy of the signed written report to the Risk Management Department.

PROCEDURES:

I. Breakage of Eyeglasses or Hearing Aids

When an employee's eyeglasses or hearing aids are broken as a result of involvement in an offender altercation and there is no additional loss of visual or auditory capacity, the damage is considered damage to personal property and is not compensable under workers' compensation. The employee may obtain reimbursement from the TDCJ in an amount not to exceed \$500 for the replacement of eyeglasses and corresponding eye exam and in an amount not to exceed \$1,000 for the repair or replacement of hearing aids. A unit assigned employee shall contact the unit supply officer to receive the reimbursement.

A non-unit assigned employee shall submit a request for reimbursement to the employee's immediate supervisor.

II. Communicable Disease Exposure

A. Employee Responsibilities

1. To qualify for workers' compensation benefits, state law requires an employee who claims a possible work-related communicable disease exposure to provide a written statement to the TDCJ documenting the date and circumstances of the exposure and documenting the fact that within 10 calendar days after the date of the exposure the employee had a test result that indicated an absence of infection.

Therefore, an employee who believes they may have been exposed to a communicable disease, such as hepatitis B, HIV, TB, or other communicable disease, as a result of the employee's work-related duties shall immediately:

- a. Complete a PERS 305, Possible Work-Related Exposure to a Communicable Disease (Attachment A), and a PERS 298, Employee's Report Packet for Workers' Compensation (Attachment C), which includes a PERS 298-2, Employee's Report of Injury or Illness;
 - b. Provide the completed PERS 305 and PERS 298 packet to the employee's supervisor; and
 - c. Contact the unit coordinator of infectious disease (CID) nurse at the nearest unit to ensure the incident qualifying as an exposure is further documented.
2. If the employee later claims to have contracted a disease due to the documented work-related exposure, the employee shall not be required to complete another PERS 298-2. The employee may contact TDI-DWC directly or report the illness through the employee's unit or department. The employee shall reference the original incident report.
 3. If an employee claims to have contracted a disease due to a previous specific work-related exposure that was not documented within 10 calendar days of the possible exposure incident, the employee may:
 - a. Contact the TDI-DWC directly; or

- b. Report the illness through the employee's unit or department by completing a PERS 298 packet. The employee should include as much information as possible concerning the original incident.

B. Supervisor Responsibilities

If an employee was involved in a work-related incident that could have exposed them to a communicable disease such as hepatitis B, HIV, or TB, the supervisor shall immediately:

1. Ensure the employee completes or has completed a PERS 305 and a PERS 298 packet;
2. Send the employee to the CID nurse for possible testing. If the employee refuses to go for possible testing, have the employee sign a statement reflecting that decision;
3. Complete and sign Part B of a PERS 298-2;
4. Ensure a PERS 299-2, Witness Statement (Attachment D), is completed for each individual identified as a witness on the employee's notice; and
5. Submit all forms to the human resources representative by the end of the shift during which the possible work-related communicable disease exposure occurred.

C. Baseline and Follow-Up Testing

The CID nurse shall make a determination on whether the incident qualifies as an exposure. Baseline testing shall be offered to the employee regardless of whether the incident qualifies as an exposure.

1. Incident Does Not Qualify as an Exposure

If the CID nurse determines the incident does not qualify as an exposure, follow-up testing shall not be authorized. If the employee wishes to have follow-up testing, the employee may contact the local or regional health department for available testing services or may be tested by the employee's personal physician at the employee's expense. Testing by personal physicians may or may not be covered by the employee's health insurance carrier or health maintenance organization (HMO).

2. Incident Qualifies as an Exposure

If the CID nurse determines the incident qualifies as an exposure, the unit physician or midlevel practitioner with the assistance of the CID nurse or designee shall thoroughly evaluate, document, and provide first aid, appropriate prophylactic, or emergency treatment for the exposure and related injuries or illness. If the employee's scope of injuries or illness exceeds the facility's capabilities to provide definitive treatment or if the exposure occurs when a physician or midlevel provider is not present, the employee may be referred to the nearest emergency facility capable of managing the injuries or illness.

If applicable, post-exposure counseling shall be provided to the employee and the employee's spouse or significant other by a medical provider trained in HIV counseling as required by state law and TDCJ policy. Follow-up testing shall be offered to the employee.

D. Human Resources Representative Responsibilities

The human resources representative shall:

1. Maintain the documentation related to the exposure in the employee's unit or department employee medical file until the incident becomes reportable (see Discussion, Section II.C.); and
2. Upon the incident becoming reportable, take the steps in Procedures, Section III.C.2.

III. Work-Related Injuries or Illnesses

A. Employee Responsibilities

When an employee sustains a work-related injury or illness in the course and scope of employment, the employee shall immediately advise the supervisor and complete a PERS 298, Employee's Report Packet for Workers' Compensation (Attachment C), to document the work-related injury or illness and elections regarding use of accrued leave. The employee shall take these steps even if the employee does not want to file a workers' compensation claim.

1. Submission of a PERS 298 Packet

The employee shall return the completed PERS 298 packet to the supervisor by the end of the shift during which the work-related injury or illness occurred. If the employee is unable to complete the PERS 298 packet and cannot designate someone to act on the employee's behalf, the

employee's supervisor shall complete the PERS 298-2, Employee's Report of Injury or Illness, and forward to the human resources representative.

2. Changes to Elections Regarding Use of Accrued Leave

Changes to elections regarding use of accrued leave may only be made in accordance with the instructions on the PERS 298-3, Employee's Election Regarding Use of Sick and Vacation Leave C-80 (Part A) or Employee's Other Time Election C-80 (Part B), which is included in the PERS 298 packet. These changes only affect subsequent periods of absence resulting from the work-related injury or illness occurring after the employee returns to work and signs a new form. The changes are not retroactive.

Changes to elections regarding use of accrued leave shall require the submission of a new and additional PERS 298-3.

3. Changes to Workers' Compensation Status

An employee shall inform the human resources representative of any changes affecting the employee's workers' compensation status as soon as practicable, for example receiving release to return to full duty, requiring additional days off, being called to service in the uniformed services, or separating employment.

4. Workers' Compensation Health Care Providers

The SORM partners with a Workers' Compensation Health Care Network (HCN) to provide employees access to approved workers' compensation health care providers. Information regarding the TDCJ's current HCN and instructions on locating an approved health care provider can be found in the PERS 298 packet or by calling an adjuster with the SORM. The Employee Network Notification Packet and the PERS 607, Workers' Compensation Network Acknowledgement Form have been incorporated into the PERS 298 packet (Attachment C).

5. TDI-DWC Work Status Report

a. If the employee incurs medical expenses, the employee shall have the health care provider complete a DWC FORM-73 or HCPS upon the following:

- (1) The employee's initial visit to the health care provider results in work restriction; or

- (2) A subsequent visit resulting in a change in treatment or work restrictions, such as an increase or decrease in work restrictions, or a release to return to work.
 - b. The employee shall provide the DWC FORM-73 or HCPS to the human resources representative via hand carry or fax in accordance with PD-46, "Medical and Parental Leave."
- 6. Permanent Mental or Physical Restrictions
 - a. An employee may be eligible for an ADA accommodation if:
 - (1) The employee receives a DWC FORM-73 showing maximum medical improvement from the health care provider identifying a permanent physical or mental restriction; and
 - (2) The permanent restriction substantially limits the employee from performing an essential function of the employee's job.
 - b. The employee may notify the accommodation coordinator, Employee Relations, Human Resources Division in accordance with PD-14, "Americans with Disabilities Act and Employment of Persons with a Permanent or Long-Term Medical Condition." The fact that an employee is awarded workers' compensation benefits, has a disability as defined by the *Texas Workers' Compensation Act*, or is assigned an impairment rating by a physician under the workers' compensation system does not automatically establish that the employee is protected by the ADA.
- 7. Return to Work
 - a. If an employee is returning to work after an initial visit to a health care provider that resulted in an absence of more than three consecutive workdays, the employee shall provide a health care provider's release to return to work via hand carry or fax in accordance with PD-46, "Medical and Parental Leave."
 - b. The employee shall provide any other required documentation to support the leave period via hand carry or fax in accordance with PD-46, "Medical and Parental Leave."

B. Supervisor Responsibilities

Supervisors shall be responsible for being familiar and complying with the guidelines set out in this directive and in the PERS 299, Supervisor's Report Packet for Workers' Compensation (Attachment D). Supervisors shall also be responsible for being familiar with the PERS 298 packet and the potential impact the elections identified on the PERS 298-1, Employee's Guidelines for Workers' Compensation, may have on the employee's monthly paycheck and other benefits. In the case of correctional employees, the shift supervisor shall assume the supervisor's responsibilities.

1. Report Packets

Supervisors shall maintain an ample supply of PERS 298 packets and PERS 299 packets.

2. Employee Submits the PERS 298 Packet

Upon receipt of a completed PERS 298 packet from the employee, the supervisor shall:

- a. Ensure the employee has reviewed the PERS 298 packet, completed all forms, and understands how the elections identified on the PERS 298-3 impact the employee's monthly paycheck and other benefits;
- b. Complete and sign Part B of PERS 298-2;
- c. Ensure a PERS 299-2, Witness Statement, is completed for each individual identified as a witness on the employee's notice; and
- d. Submit all forms to the human resources representative by the end of the shift during which the work-related injury or illness occurred.

3. Employee Unable to Complete the PERS 298 Packet

The supervisor shall be responsible for completing the PERS 298-2 and submitting the documents to the human resources representative if:

- a. The supervisor is aware of a work-related injury or illness for which the employee did not complete or was unable to complete the required paperwork by the end of the shift during which the work-related injury or illness occurred; and

- b. The employee was unable to designate someone to act on the employee's behalf.

4. Leave Management

Supervisors shall coordinate with the human resources representative to ensure employee leaves are managed in accordance with applicable TDCJ policies and to ensure qualified absences are appropriately designated as family and medical leave (FML).

5. Employee's Return to Work or Other Change in Status

- a. A supervisor shall allow an employee to return to work if the employee has been off more than three consecutive workdays and provides a release to return to work.
- b. Upon becoming aware of any change in the employee's status by means other than notice from the human resources representative, the supervisor shall complete a PERS 299-3, Supplemental Worksheet, and submit the PERS 299-3 to the human resources representative's office by the end of the shift during which the supervisor becomes aware that the employee:
 - (1) Is returning to duty after being absent due to the work-related injury or illness. Prior to performing job duties, the employee must submit a DWC FORM-73 or HCPS releasing the employee to full duty without restrictions if the employee was absent for more than three consecutive workdays;
 - (2) Was on leave without pay;
 - (3) Is returning to work after the employee's initial visit to the health care provider;
 - (4) Requires additional days off due to the initial work-related injury or illness;
 - (5) Is called to service in the uniformed services while on leave without pay;
 - (6) Resigns or is separated from employment; or
 - (7) Dies.

C. Human Resources Representative Responsibilities

1. Program Administration

Human resources representatives are responsible for the overall administration of the Workers' Compensation and Return to Work Program procedures within the unit or department. These responsibilities include the following:

- a. Maintaining and making available to supervisors an ample supply of PERS 298 packets, PERS 299 packets, and PERS 305 forms;
- b. Upon being notified of a work-related injury or illness, verifying the supervisor provided the employee with a PERS 298 packet, and a copy of the employee's applicable job description;
- c. Being thoroughly familiar with the impact the elections identified on the PERS 298-1 may have on an employee's paycheck and benefits;
- d. Ensuring supervisors and employees are trained in the reporting of workers' compensation claims and indicating that employees fully understand the impact the elections identified on the PERS 298-1 may have on an employee's paycheck and benefits;
- e. Communicating with the employee the importance of completing the PERS 298-3 (Part A);
- f. Ensuring employees indicate they understand the various leave options;
- g. Communicating with an injured or ill employee on a regular basis during the employee's recuperation from a compensable work-related injury or illness, until the employee is able to return to work.
- h. Complying with the provisions in this directive and the provisions of TDCJ leave policies;
- i. Posting required workers' compensation posters in common use areas; and
- j. Maintaining all documentation relating to an employee's work-related injury or illness in the employee's unit or department medical file.

2. Reporting for TDCJ Employees Assigned to the Unit or Department

The human resources representative is responsible for the following:

- a. Ensuring appropriate documentation is completed within one workday after any work-related injury or illness occurs.
- b. Providing the appropriate safety officer with a copy of the PERS 298-2 and a copy of any PERS 299-2 within one workday to assist the safety officer in the investigation of the workers' compensation incident and claim.
- c. Submitting, via fax, email, or hand delivery, the appropriate documentation, including the cover letter (Attachment B) to the Workers' Compensation Program Area and SORM within one workday after the work-related injury or illness becomes reportable.
- d. If parts A and B of the PERS 298-3 were not submitted with a PERS 298 packet, the human resources representative should contact the employee immediately to complete these forms within one workday to avoid automatic "Election 1" by SORM.
- e. Generating a Workers' Compensation Change Status (WORK_SUPP) e-form, no later than one workday after the employee has a reportable change in status, such as:
 - (1) Returns to duty after being absent due to the work-related injury or illness;
 - (2) Requires additional days off due to the initial work-related injury or illness;
 - (3) Exhausts sick leave and vacation leave balance due to the work-related injury or illness, which only applies to employees who choose Election 1 on Part A of the PERS 298-3;
 - (4) Is placed in approved leave without pay status due to the work-related injury or illness;
 - (5) Has a change in approved leave without pay status due to the work-related injury or illness;

- (6) Has received donated sick leave, approval of extended sick leave with pay, or withdrawals from the sick leave pool due to the work-related injury or illness;
- (7) Is called to service in the uniformed services while on leave without pay;
- (8) Resigns or is separated from employment; or
- (9) Dies.

3. Reporting for Windham School District (WSD) Employees

When an employee who works for the WSD sustains a work-related injury or illness, the TDCJ unit or department human resources representative where the employee is assigned shall coordinate with the WSD Human Resources Department to ensure the applicable guidelines in Procedures, Section III.C.2 are followed. The unit or department human resources representative shall forward a copy of all documentation related to the work-related injury or illness to the WSD Human Resources Department for maintenance.

4. Reporting for Employees Attending Pre-Service or In-Service Training

When an employee sustains a work-related injury or illness while attending pre-service or in-service training, the pre-service or in-service human resources representative shall follow the applicable guidelines in Procedures, Section III.C.2.

5. Denial of Claims

A notification from SORM is sent to both the Workers' Compensation Program Area and the employee via first class mail if the employee's claim is denied. Upon receipt of notification from the Workers' Compensation Program Area that SORM has denied liability for an employee's claim or has indicated an employee's lost time should no longer be considered work-related, the human resources representative shall attempt to contact the employee to assist the employee in adjusting the employee's leave status.

IV. Return to Work Program Temporary Alternate or Modified Duty Assignments

A. General Provisions

1. The identification, assignment, and management of temporary alternate or modified duty assignment positions shall be handled on a case-by-case basis as warranted by the business necessity of the TDCJ.
2. Temporary alternate or modified duty assignments shall be physically located at the same unit or department as the employee's assignment at the time the employee sustained or incurred the work-related injury or illness or at a unit or department within the same pooled area. See Return to Work Program Pooled Areas (Attachment E).
3. A temporary alternate or modified duty assignment shall begin on the first day the employee reports to work for the assignment. An employee may work intermittently during the assignment.
4. The assignment shall continue for a maximum period of 12 consecutive workweeks per work-related injury or illness, even if the employee:
 - a. Experiences additional absences due to injury or illness; or
 - b. Is certified to return to full duty by the health care provider, then experiences additional absences due to injury or illness and is subsequently released to the temporary duty assignment once again.
5. The assignment shall end and not be extended when the 12 consecutive workweeks expire.
6. If an employee incurs a subsequent unrelated injury or illness while performing the temporary alternate or modified duty assignment, the assignment shall not be extended to accommodate the subsequent unrelated injury or illness. An employee shall return to full duty from the injury or illness that resulted in the temporary alternate or modified duty assignment prior to being offered another temporary alternate or modified duty assignment for a subsequent unrelated injury or illness.

B. Warden or Department Head Responsibilities

The warden or department head shall identify temporary alternate or modified duty assignments to facilitate return to work based on the TDCJ's business necessity. Identification of temporary alternate or modified duty assignments shall be coordinated with the supervisor and human resources representative. If

no temporary alternate or modified duty assignments are available within the warden's or department head's unit or department, the warden or department head shall be responsible for contacting other units or departments within the same pooled area to determine availability of such assignments.

C. Human Resources Representative Responsibilities

Human resources representatives are responsible for the overall administration of the Return to Work Program within the unit or department. Human resources representatives shall be thoroughly familiar with the impact the Return to Work Program may have on an employee's status of employment, paycheck, employment benefits, and workers' compensation benefits.

The employee's human resources representative shall also be responsible for the following:

1. Upon receipt of the DWC FORM-73 or HCPS authorizing a temporary alternate or modified duty assignment, the human resources representative shall:
 - a. Coordinate with the warden or department head to identify a temporary alternate or modified duty assignment;
 - b. Identify the begin date for the temporary alternate or modified duty assignment based on the DWC FORM-73 or HCPS; and
 - c. Attempt to contact the employee by telephone and read the PERS 376, Offer of Temporary Alternate or Modified Duty Assignment (Attachment F), to the employee. If the human resources representative is unable to reach the employee via telephone or if the employee rejects the initial assignment over the phone, the human resources representative shall mail the PERS 376 to the employee, via certified mail, return receipt requested, and forward one copy to the employee's supervisor.

If within three workdays of receipt of the certified mailed PERS 376 an employee fails to either contact the human resources representative or return the signed form indicating acceptance or rejection to the human resources representative, the failure to do so shall be considered an official rejection of the assignment.

2. Upon an employee's verbal or written acceptance of the assignment, the human resources representative shall:
 - a. Instruct the employee to report to the human resources representative on the employee's first day of assignment; and
 - b. Notify the employee's supervisor and the temporary alternate or modified duty assignment supervisor, if different from the employee's supervisor, of the employee's acceptance of the assignment.
3. When the employee reports to the human resources representative on the first day of assignment, the human resources representative shall:
 - a. Ensure the employee indicates acknowledgement of the temporary duty assignment period by signing the PERS 376 in the appropriate space;
 - b. Immediately notify the employee's supervisor and the temporary alternate or modified duty assignment supervisor, if different from the employee's supervisor;
 - c. Forward a copy of the signed PERS 376 to the employee's supervisor and the temporary alternate or modified duty assignment supervisor, if different from the employee's supervisor, to the Workers' Compensation Program Area, and to SORM, via fax; and
 - d. Continue to be responsible for any of the employee's human resources related services while the employee is performing the temporary alternate or modified duty assignment, including reporting of time, even if the employee's temporary alternate or modified duty assignment is at another unit within the pooled area.
4. Upon the employee's official rejection of the assignment, such as a signed PERS 376 indicating rejection, or failure to respond to the PERS 376 mailed via certified mail, immediately notify the employee's supervisor and the Workers' Compensation Program Area. If applicable, the human resources representative shall retain the original PERS 376 and forward one copy of the signed PERS 376 to the employee's supervisor and the Workers' Compensation Program Area. If the employee did not return a signed PERS 376, the human resources representative shall document the employee's failure to do so on the PERS 376, retain the original documentation, and fax a copy to SORM, the employee's supervisor, and the Workers' Compensation Program Area.

5. Within 24 hours of receipt of the employee's official acceptance or rejection of an Offer of Temporary Alternate or Modified Duty Assignment, the human resources representative shall generate a Workers' Compensation Change Status (WORK_SUPP) e-form. If the email system is not available, a copy of the completed Supplemental Worksheet should be faxed to the Workers' Compensation Program Area, Human Resources Headquarters.
6. At the end of the temporary alternate or modified duty assignment, the human resources representative shall:
 - a. Have the employee sign the original PERS 376, indicating the employee's acknowledgement of the expiration of the assignment.
 - b. Immediately forward a copy of the signed PERS 376 to the employee's supervisor.
 - c. If the employee has been certified by the health care provider to return to full duty, return the employee to the same position the employee held at the time the work-related injury or illness was sustained or incurred.
 - d. If the employee has not been certified by the health care provider to return to full duty, place the employee in the appropriate leave status in accordance with TDCJ leave policies or separate the employee as applicable.
7. The human resources representative shall be responsible for maintaining all original documentation pertaining to the temporary alternate or modified duty assignment in the employee's unit or department medical file.

D. Employee Responsibilities

1. An employee may receive a verbal offer for a temporary duty assignment or a written PERS 376 from the human resources representative. If an employee receives a verbal offer, the employee shall inform the human resources representative of acceptance or rejection of the assignment at the time the offer is made.

If the employee rejects a verbal offer or the employee cannot be reached by phone, a PERS 376 shall be mailed to the employee via certified mail, return receipt requested. Within three workdays of receipt of the PERS 376, the employee shall either contact the human resources representative to verbally accept the assignment or return the signed PERS 376 to the

human resources representative indicating acceptance or rejection of the assignment. If an employee fails to contact the human resources representative or return the PERS 376 indicating acceptance or rejection within three workdays of receipt, the assignment shall be considered as officially rejected.

2. If an employee accepts a temporary alternate or modified duty assignment, the employee shall report to the human resources representative on the first day of the assignment and sign the PERS 376. The employee shall perform the duties of the temporary alternate or modified duty assignment for a maximum period of 12 consecutive workweeks per work-related injury or illness or until the employee is certified by the health care provider to return to full duty, whichever occurs first.
3. If the temporary alternate or modified duty assignment supervisor is not the employee's regular supervisor, the employee shall have the temporary alternate or modified duty assignment supervisor approve and sign the employee's time sheets and fax or hand carry the signed time sheets to the employee's human resources representative.
4. If the employee receives certification by the health care provider to return to full duty, the employee shall notify the human resources representative of the change in status as soon as practicable and before reporting to work.
5. If the employee has not been certified by the health care provider to return to full duty at the completion of the temporary alternate or modified duty assignment, the employee shall coordinate leave through the human resources representative in accordance with TDCJ leave policies.

Brad Livingston
Executive Director

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Possible Work-Related Exposure to a Communicable Disease

Employee Name and Mailing Address	Employee Social Security Number
Name:	
Mailing Address:	Date of Possible Exposure
City, State, and Zip Code:	

If you contract a disease as a result of this work-related exposure, you may file a claim for workers' compensation. To qualify for workers' compensation benefits, the law requires that you provide:

- A written statement that includes the date and circumstances of the exposure; and
- Documentation that you were tested within 10 calendar days after the date of the exposure to establish baseline test results. Texas Department of Criminal Justice (TDCJ) personnel do not have access to these test results.

For your records, attached is a PERS 298, Employee's Report Packet for Workers' Compensation. A copy of these reports shall be maintained in your unit or department medical file.

A possible work-related exposure to a communicable disease is not reportable as a workers' compensation illness unless you later contract the disease. If you should contract a disease as a result of this possible exposure, you may initiate a report through this office. Since we have no access to your test results, you are required to provide documentation of the test you had within 10 days after the exposure to accompany the report.

If you prefer not to initiate a report through this office, you may also report the incident directly to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) by calling 1-800-252-7031 or contacting a local TDI-DWC field office.

Employee Statement: _____

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

HUMAN RESOURCES REPRESENTATIVE:

Name (Printed)

Signature

Date (mm/dd/yyyy)

Phone Number

Attachment(s)

c: Unit or Department Medical File



Texas Department of Criminal Justice

Brad Livingston
Executive Director

Date Faxed: _____

THE STATE OFFICE OF RISK MANAGEMENT

Workers' Compensation Division

Fax #: (512) 370-9025

Human Resources Headquarters

Fax #: (936) 437-4140

RE: NAME: _____

SSN: _____

DATE OF INJURY OR ILLNESS: _____

The original report for the above injury or illness is attached. Your office was initially notified by the Agency's Workers' Compensation department via entry into the SORM on-line system.

Sincerely,

Signature

Human Resources Representative: _____

Telephone: _____

Unit/Department Name: _____

Unit/Department Address: _____

Attachments:

cc: Unit or Department Medical File

Our mission is to provide public safety, promote positive change in offender behavior, reintegrate offenders into society, and assist victims of crime.

Human Resources Division
2 Financial Plaza, Ste. 600, Huntsville, Texas 77340
www.tdcj.texas.gov

**Texas Department of Criminal Justice
Employee's Report Packet for Workers' Compensation**

CONTENTS

PERS 298-1, Employee's Guidelines for Workers' Compensation

PERS 298-2, Employee's Report of Injury or Illness

**PERS 298-3, Employee's Election Regarding Use of Sick and Vacation Leave C-80 (Part A)
and Employee's Other Time Election C-80 (Part B)**

PERS 298-4, Authorization for Release of Information (Form No. SORM-16 9-98)

**PERS 298-5, Employee's Acknowledgement of Responsibilities Relating to Work-Related
Injury or Illness**

DWC FORM-48, Request for Travel Reimbursement

myMatrixx Worker's Compensation Prescription Information

IMO Med-Select Employee Network Notification Packet

**PERS 607, Workers' Compensation Network Acknowledgement (Page two of the
Employee Network Notification Packet)**

DWC FORM-73, Texas Workers' Compensation Work Status Report – This form shall be
provided by the human resources representative.

Texas Department of Criminal Justice Employee's Guidelines for Workers' Compensation

COMPLETION OF THE EMPLOYEE'S PACKET

- ◆ Complete the forms located in the PERS 298, Employee's Report Packet for Workers' Compensation any time you sustain a work-related injury or illness (whether or not you plan on filing a workers' compensation claim) or when you believe you may have been exposed to a communicable disease as a result of your work-related duties. If you believe you may have been exposed to a communicable disease, you are also required to complete a PERS 305, Possible Work-Related Exposure to a Communicable Disease (Attachment A) and contact the unit coordinator of infectious disease (CID) nurse at the nearest unit for baseline testing.

It is your responsibility to review the PERS 298 packet and understand the impact that the elections on the PERS 298-3, Employee's Election Regarding Use of Sick and Vacation Leave C-80 (Part A), and Employee's Other Time Election C-80 (Part B) may have on your state benefits. You should contact your supervisor or human resources representative for additional information to ensure that you understand the impact of the C-80 elections.

- ◆ Submit the completed PERS 298 packet to your supervisor by the end of the same shift the injury or illness occurs.
- ◆ Designate a person to act on your behalf if you are unable to complete the PERS 298 packet, or your supervisor shall complete the PERS 298-2 for you.
- ◆ General guidance for each form in the PERS 298 packet:

☒ PERS 298-2, Employee's Report of Injury or Illness: Complete each blank in Part A (1-12) and sign and date the form before you submit it to your supervisor, who shall complete Part B.

☒ PERS 298-3, Employee's Election Regarding Use of Sick and Vacation Leave C-80 and Employee's Other Time Election C-80 (Parts A and B): You may change your elections to Part A until you have reached your eighth day of workers' compensation disability. The eight days do not have to be consecutive. A change to Part B may only be made when you return to work. Changes shall only affect subsequent periods of absence resulting from the work-related injury or illness that occur after you sign the revised form. The changes shall not be retroactive. **As previously stated, it is your responsibility to understand how the elections you choose may impact your pay and other benefits as described under the heading "Effect of C-80 Elections on Benefits."** A description of these elections follows:

C-80 Part A: Addresses the use of accrued sick and vacation leave and establishes the initial compensation payment start date. You may not receive workers' compensation income benefits while using accrued sick leave, including sick leave pool, donated sick leave, or extended sick leave, or accrued vacation leave. There shall be a waiting period of seven calendar days before workers' compensation benefits begin. To the extent these benefits are available, Part A allows you to:

Election 1: Exhaust all accrued sick leave and then all or part of accrued vacation leave before receiving any workers' compensation payments.

Election 2: Not use any accrued sick leave or vacation leave, thereby freezing your sick and vacation leave balances.

Accrued compensatory, holiday, and overtime may be used during the waiting period of seven calendar days as indicated in Part B. If you do not elect to use sick leave during the seven-day waiting period and you are on leave for your work-related injury or illness for 28 days or more, you shall receive an additional payment to reimburse you for the waiting period.

C-80 Part B: After Part A sick and vacation leave elections are made, Part B elections shall determine how accrued compensatory, holiday, and overtime are to be used during your absence due to the work-related injury or illness. To the extent you are eligible for these benefits, Part B allows you to:

Election 1: Exhaust all eligible accrued time in the following order: compensatory, holiday, and overtime.

Election 2: Not use any accrued compensatory, holiday, or overtime, thereby freezing all balances until after returning to work.

Election 3: Use a portion of accrued time, thereby freezing remaining balances until returning to work.

If you elect to freeze your accrued compensatory and holiday time and as a result of your injury are unable to use the time before it expires, the time shall not be restored.

If you elect to freeze your accrued time and upon exhaustion of the 180 days leave without pay-medical (LWOP-Medical) period you have not physically returned to work, you shall be placed on the active payroll until all accrued compensatory and holiday time is exhausted. After all accrued compensatory and holiday time is exhausted, you shall then be separated from employment and your accruals of overtime and vacation leave shall be handled in accordance with PD-49, "Leaves Other than Medical or Parental."

- ☒ PERS 298-4, Authorization for Release of Information (SORM-16): Complete, sign, and date.
- ☒ DWC FORM-48, Request for Travel Reimbursement: Please read the information provided to determine if you have travel expenses that are eligible for reimbursement.
- ☒ DWC FORM-73, Texas Workers' Compensation Work Status Report instructions.

EFFECT OF C-80 ELECTIONS ON BENEFITS

While unable to work due to the work-related injury or illness, your benefits are affected. Refer to the following information and to the table entitled C-80 Election Combinations of this attachment for assistance in choosing the elections that you consider best for you.

◆ LEAVE

For continued employment with TDCJ, you are required to comply with PD-46, "Medical and Parental Leave," or PD-49, "Leaves Other than Medical or Parental." You are required to provide a DWC FORM-73 or health care provider's statement (HCPS) before you return to work if, as a result of the work-related injury or illness you: (a) were absent for more than three days or your HCPS or DWC FORM-73 indicates restrictions; or (b) were placed in LWOP status.

When submitting a PERS 24, Leave Request, attach an HCPS for the requested leave period. The requested leave period shall not exceed six months, or the date the health care provider has indicated you may return to work.

Leave with Pay: While using accrued sick, vacation, compensatory, holiday, or overtime, you are on leave with pay. You may also be eligible to receive additional benefits, to include:

Extended Sick Leave: You are required to have at least five years of TDCJ service accrued since your most recent hire date, 56 hours of sick leave balance accrued since your most recent hire date at the onset or initial diagnosis of the current injury or illness sick leave pool request, and not have used 12 workweeks of extended sick leave in the past five years. All accrued time balances shall be exhausted.

Sick Leave Pool: You are required to meet the eligibility criteria in PD-50, "Sick Leave Pool," including the requirement to have at least 12 months of TDCJ service accrued since your most recent hire date, 56 hours of sick leave balance accrued since your most recent hire date at the time of the current injury or illness sick leave pool request, and you shall not have withdrawn from the sick leave pool during the current fiscal year. All of your accrued time balances shall first be exhausted.

Donated Sick Leave: You are required to have exhausted all accrued sick leave, including any time you may be eligible to withdraw from the sick leave pool.

If you choose to freeze any portion of your accrued time balances, you shall not be eligible to apply for extended sick leave or sick leave pool.

If you choose to freeze any portion of your accrued sick leave, you shall not be eligible to receive any donated sick leave.

Leave without Pay-Medical (LWOP-Medical): Before your leave with pay is exhausted, you shall request LWOP-Medical in accordance with PD-46, "Medical and Parental Leave."

Family and Medical Leave (FML): The human resources representative shall determine whether or not your absence due to a work-related injury or illness should be designated as FML, either with pay or without pay. You may qualify for FML if you:

- Have at least 12 months of state service;
- Suffer from a serious health condition;
- Have worked at least 1,250 hours during the previous year; and
- Have not used more than 12 workweeks of FML in the previous 12 months.

◆ **INITIAL VISIT TO A HEALTH CARE PROVIDER/RETURN TO WORK**

Regardless of when the injury or illness occurred, you are required to notify your supervisor as soon as you incur medical expenses resulting from the work-related injury or illness or you are off work a full shift due to the work-related injury or illness, so that your supervisor can notify the human resources representative of your change in status.

You are responsible for ensuring that the health care provider who provides medical services has been approved by the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to treat IMO Med-Select Network workers' compensation injured employees. You may call your adjuster at the State Office of Risk Management (SORM) or TDI-DWC, or access the TDI-DWC website at www.tdi.texas.gov to ensure that your health care provider treats workers' compensation injured employees.

Upon your initial visit to an IMO Med-Select Network health care provider, you shall provide the IMO Med-Select Network health care provider with a copy of the job description that was provided to you by your supervisor. The health care provider should provide you with a completed DWC FORM-73. (The health care provider will have a DWC FORM-73 on hand, because the TDI-DWC requires health care providers to use this form.)

You are required to provide the DWC FORM-73 or an HCPS from your initial visit to your human resources representative in accordance with PD-46, "Medical and Parental Leave," via hand carry or fax. The DWC FORM-73 or HCPS shall indicate one of the following:

- 1) You qualify to participate in a temporary alternate or modified duty assignment position.

If you qualify for a temporary alternate or modified duty assignment, a verbal or written offer shall be made by the human resources representative. A rejection shall be reported to SORM and any applicable workers' compensation benefits may be readjusted. You should continue to coordinate leave through your human resources representative in accordance with TDCJ policies.

- 2) Based on the restrictions indicated, you are not eligible to return to work at the present time.

If you are absent more than three consecutive days, you shall be required to also provide your supervisor with a PERS 24, Leave Request, and an HCPS that includes the medical facts in accordance with PD-46, "Medical and Parental Leave."

◆ **SUBSEQUENT VISITS TO THE HEALTH CARE PROVIDER**

If a subsequent visit to the health care provider results in a change in treatment or work restrictions, you are required to provide, via hand carry or fax, a subsequent DWC FORM-73 or HCPS to your human resources representative within one workday of the subsequent visit.

◆ **RETURN TO WORK WITH ACCOMMODATIONS**

Employees with permanent restrictions may apply for accommodations in accordance with PD-14, "Americans with Disabilities Act and Employment of Persons with a Permanent or Long-Term Medical Condition."

◆ **WORKERS' COMPENSATION**

Workers' compensation benefit payments replace only a percentage of your regular pay; however, the benefit payments are not subject to social security, withholding taxes, or the mandatory retirement contribution to the Employees Retirement System (ERS).

You **cannot** receive workers' compensation payments while using accrued sick leave, sick leave pool, extended sick leave, or vacation leave.

You **can** receive workers' compensation payments while using accrued overtime, holiday, or compensatory time if you elect to use this time on the C-80 elections.

◆ **GROUP INSURANCE**

Disability (if applicable):

Payments begin after a waiting period of 30 days (short-term disability) or 90 days (long-term disability) after the date lost time began or after accrued sick leave is exhausted, whichever is greater, or after extended sick leave or sick leave pool payments cease. Payments are reduced by the amount of your workers' compensation payments.

Long-term disability applies only if an approved attending physician certifies that you are totally disabled.

Health Coverage: You shall receive a detailed letter from the ERS, if you are required to make payments. Payments shall be made by cashier's check or money order.

While on leave with pay: The state contribution to your insurance continues, and your portion of the premium shall be deducted from your paycheck.

While on LWOP designated as FML: The state contribution continues, so you shall only be responsible for paying your portion of the premium.

While on LWOP not designated as FML: No state contribution shall be paid; therefore, you shall be responsible for the entire premium if you are in LWOP status that is not designated as FML for a complete month. However, your workers' compensation payment amount increases to compensate for the decrease in the state contribution for the employee's health insurance only.

If you do not pay your group insurance premium, your coverage shall be cancelled effective the last day of the month for which no payment has been made. To reinstate cancelled coverage, apply through your human resources representative as soon as you return to work.

◆ **OTHER BENEFITS**

If you are participating in voluntary benefit programs, such as 457 Deferred Compensation Plan, 401(k) TexaSaver Plan, Texas Tuition Promise Fund, TexFlex, or Service Purchase Installment Program, payroll deductions shall continue in effect until your TDCJ paycheck is no longer sufficient to cover your deductions unless you request that the deductions be discontinued at an earlier date.

◆ **PAYMENT OF MEDICAL BILLS AND PRESCRIPTIONS**

Inform the attending physician, hospital, and pharmacist that medical claims and prescriptions are to be filed as workers' compensation. Except for emergency care, the attending physician should request pre-certification through SORM.

If the claim is approved, liability for payment of medical services, prescriptions, etc. shall be assumed by SORM. Your human resources representative or the Workers' Compensation Program Area, Human Resources Division, can verify that a work-related injury or illness has occurred, but neither can accept liability for payment. Claims for payment of medical bills or prescriptions shall be considered and paid by SORM only after an itemized bill is submitted to SORM which includes the employee's name, social security number, and date of injury. Employees are responsible for providing copies of physician's statements to adjusters as required.

The attending physician should direct any questions about workers' compensation and mail all bills and reports to:

State Office of Risk Management
P.O. Box 13777
Austin, Texas 78711-3777
Phone 512-475-1440

◆ **PROBLEMS WITH CLAIMS**

Any problems you may have with claims should be referred to your SORM claims adjuster at the address and telephone number indicated above.

◆ **DENIED CLAIMS**

If your claim is denied by SORM and you are unable to return to work, you shall contact your human resources representative to determine your leave options. Contact your local TDI-DWC office or write your claims adjuster at the address indicated for SORM regarding your right to appeal a denied claim.

◆ **FRAUD**

If you knowingly or intentionally perform any of the following acts in an attempt to obtain workers' compensation benefits, you may have committed a Class B administrative violation that is punishable by an administrative penalty not to exceed \$5,000:

- Make a false or misleading material statement.
- Misrepresent or conceal a material fact.
- Fabricate, alter, conceal, or destroy a document.
- Conspire to commit an act as listed above.

◆ **DENTAL**

Should you require dental services for your injury that is not due to an emergency, you shall obtain pre-authorization from SORM prior to services being provided.

◆ **MULTIPLE EMPLOYMENT**

If you have other employment in addition to TDCJ, you may be eligible to report those wages to increase your weekly benefit. Please contact SORM directly at 512-475-1440 for additional eligibility information.

C-80 ELECTION COMBINATIONS

Part A	Part B	Impact of Elections on Pay and Benefits
1	1	Elects to use all accrued sick leave then all or part of vacation leave and other time. <ul style="list-style-type: none"> - Pay and insurance coverage continues until accrued time is depleted. See Notes 1 and 2. - Workers' compensation pay begins after sick and vacation leave is depleted. See Notes 3 and 4. - May apply for extended sick leave and sick leave pool, if eligible, prior to all time being depleted. - May receive donated sick leave hours.
1	2	Elects to use all accrued sick leave then all or part of vacation leave and freezes other time. <ul style="list-style-type: none"> - Pay and insurance coverage continues until accrued sick and vacation leave is depleted. See Note 2. - Workers' compensation pay begins after sick and vacation leave is depleted. See Note 3. - Ineligible to apply for extended sick leave and sick leave pool since other accrued time is not depleted. - May receive donated sick leave hours.
1	3	Elects to use all accrued sick leave then all or part of vacation leave and use a portion of other time. <ul style="list-style-type: none"> - Pay and insurance coverage continues until sick and vacation leave is depleted and other time reaches specified levels. See Notes 1 and 2. - Workers' compensation pay begins after sick and vacation leave is depleted. See Notes 3 and 4. - Ineligible to apply for extended sick leave and sick leave pool since other accrued time is not depleted. - May receive donated sick leave hours.
2	1	Elects not to use accrued sick or vacation leave. Use other time until balances are depleted. <ul style="list-style-type: none"> - Pay and insurance coverage continues until accrued time is depleted. See Notes 1 and 2. - Workers' compensation pay begins after the waiting period of seven calendar days. See Notes 3 and 4. - Ineligible to apply for extended sick leave and sick leave pool since sick or vacation leave is not depleted. - Ineligible to receive donated sick leave since sick leave is not depleted.
2	2	Elects not to use accrued sick or vacation leave and freezes other time. <ul style="list-style-type: none"> - Pay and insurance coverage stops. See Note 2. - Workers' compensation pay begins after the waiting period of seven calendar days. See Note 3. - Ineligible to apply for extended sick leave and sick leave pool since accrued sick or vacation leave or other time is not depleted. - Ineligible to receive donated sick leave since sick leave is not depleted.
2	3	Elects not to use accrued sick or vacation leave and use a portion of other time. <ul style="list-style-type: none"> - Pay and insurance coverage continues until other time reaches specified levels. See Notes 1 and 2. - Workers' compensation pay begins after the waiting period of seven calendar days. See Notes 3 and 4. - Ineligible to apply for extended sick leave and sick leave pool since accrued sick or vacation leave or other time is not depleted. - Ineligible to receive donated sick leave since sick leave is not depleted.

Note 1: "Other time" includes compensatory, holiday, and overtime.

Note 2: You are required to apply for LWOP-Medical prior to the depletion of all accrued time. If in LWOP status, you shall be responsible for the payment of all insurance premiums. If on FML, the state paid portion of the insurance premium continues, but you shall continue to be responsible for payment for any coverage, such as family, beyond that.

Note 3: If eligible for short term disability insurance, payments do not begin until after 30 days or sick leave is depleted, whichever is greater. You cannot draw short term disability payments and use sick leave simultaneously.

Note 4: You cannot draw workers' compensation benefits while using accrued sick or vacation leave.

Texas Department of Criminal Justice Employee's Report of Injury or Illness

HUMAN RESOURCES
REPORTABLE () Y () N
LOST TIME () Y () N

PART A: EMPLOYEE OR DESIGNEE (CLEARLY PRINT THE FOLLOWING INFORMATION)

1. Employee's Payroll Name: (Last, First, MI) _____
 Current Mailing Address: _____ Email: _____
 City: _____ County: _____
 State: _____ Zip Code: _____
 Social Security Number: _____ Home Phone Number: _____
 Date of Birth (mm/dd/yyyy): _____ Gender: _____
2. Marital Status (check one): ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced
3. Number of Dependent Children: _____ Name of Spouse: _____
4. Did you receive treatment from a physician for this injury or illness? (check one) ☐ Yes ☐ No
 Did you incur medical expenses? ☐ Yes ☐ No
5. If medical expenses were incurred, provide the following information:
 Attending Physician's Name: _____ Hospital: _____
 Mailing Address: _____ City: _____ State: _____ Zip Code: _____
6. Date of injury or illness: _____ Time of injury or illness: _____ (check one) ☐ AM ☐ PM
 Are you a third shift employee: ☐ Yes ☐ No If third shift, date shift actually began: _____
7. Unit or department where the injury or illness occurred: _____
8. Nature of injury (cut, bruise, etc.): _____
 Part(s) of body affected: _____
9. Detailed description of how the injury or illness occurred: _____

10. Were you performing normal job duties? (check one) ☐ Yes ☐ No
 Work site where injury or illness occurred (stairs, dock, etc.): _____
11. Cause of injury or illness (fall, tool, machine, offender, etc.): _____
12. Full name(s) of witness(es) (If offender, include TDCJ#): _____

I certify that the above injury or illness was not caused by my intent, willful misconduct, or neglect. I acknowledge receipt and understanding of the Workers' Compensation Employee's Guidelines.

Signature of Employee: _____ Date: _____

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

PART B: SUPERVISOR ACKNOWLEDGEMENT OF INJURY OR ILLNESS

13. Part A of this form was completed by: (check one) ☐ Employee ☐ Designee Phone No. ()
If designee, full name of the designee: SSN:
14. First full shift the employee was unable to work due to injury or illness (if no time lost, enter "NLT"):
15. Was the employee able to return to work since missing a full shift? ☐ Yes ☐ No ☐ Did not lose full shift
If yes, check one of the following: ☐ Full Duty ☐ Temporary Alternate/Modified Duty
16. Has the employee been placed in a leave status? (check one) ☐ Yes ☐ No
If yes, type of leave: Effective date:
17. Did employee die? ☐ Yes ☐ No
18. Full Name of Supervisor: Supervisor's SSN:
Date the employee reported the injury or illness to you:
19. Employee's choice of sick leave election (C-80, Part A) (check one) ☐ 1 ☐ 2
Employee's choice of other time election (C-80, Part B) (check one) ☐ 1 ☐ 2 ☐ 3
Sick leave balance on date of injury:
Vacation balance on date of injury: Amount of vacation time elected to be used:
20. If this report is not being submitted within one workday of the occurrence of the injury or illness, check the appropriate box and complete required information:
- ☐ Medical expenses incurred on:
☐ First full shift missed on:
☐ Other:

The above injury or illness was reported to me as indicated above. **I acknowledge receipt and understanding of the Supervisor's Guidelines.** I acknowledge the above information to be true and accurate to the best of my knowledge.

Signature of Supervisor: Date:

Distribution:

ORIGINAL - State Office of Risk Management
COPY - Workers' Compensation Program Area, Human Resources Division
COPY - Unit or Department Medical File
COPY - Risk Management Coordinator
COPY - Employee

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Employee's Election Regarding Use of Sick and Vacation Leave
C-80 (Part A)
(Texas Labor Code § 501.044)

Employee's Name: _____ Date of Injury or Illness: _____

MM/DD/YYYY

Employee's SSN: _____

Hours of Sick Leave Available
as of Date of Injury or Illness: _____

Hours of Vacation Leave Available
as of Date of Injury or Illness: _____

Complete Election 1 or Election 2.

ELECTION 1 (Choose A, B, or C)

When I lose time from work due to this injury or illness I elect to use all of my accrued sick leave **AND**:

- ☐ **A.** All of my accrued vacation leave.
- ☐ **B.** A portion of my accrued vacation leave (enter number of hours: _____).
- ☐ **C.** None of my accrued vacation leave.

Sick leave shall be exhausted before vacation leave can be used.

I understand I cannot receive workers' compensation payments while using sick leave, sick leave pool, extended sick leave, or vacation leave.

ELECTION 2

- ☐ When I lose time from work due to this injury or illness, I elect to **not** use any accrued sick leave and not use any accrued vacation leave. I understand I shall not receive workers' compensation payments until after the waiting period of seven calendar days.

MONTHLY TEMPORARY INCOME BENEFITS ELECTION

- ☐ I elect to change my Temporary Income Benefits frequency from weekly to monthly.

I have read the Employee's Guidelines and understand the effect this election may have on my paycheck and benefits and that it shall affect any and all future occurrences of lost time as a result of this work-related injury or illness. I further understand that **I MAY NOT** change this Part A election after my eighth day of workers' compensation disability and signing this form.

(Employee's Signature/Date)

(Supervisor's or Human Resources Representative's Signature/Date)

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

Distribution:

Reportable: ORIGINAL – State Office of Risk Management
COPY – Workers' Compensation Program Area, Human Resources Division
COPY – Unit or Department Medical File
COPY – Employee

Not Reportable: ORIGINAL – Unit or Department Medical File
COPY – Employee

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Employee's Other Time Election
C-80 (Part B)

Choose one of the following elections by initialing in the space beside it:

_____ **ELECTION 1**

When I lose time from work due to this injury or illness, I hereby elect to use all my accrued compensatory, holiday, and overtime UNTIL THE BALANCES ARE EXHAUSTED or I return to work, whichever occurs first.

_____ **ELECTION 2**

When I lose time from work due to this injury or illness, I hereby elect TO NOT USE ANY accrued compensatory, holiday, and overtime, thereby freezing all balances until I return to work. I understand I may not receive workers' compensation benefits until after the waiting period of seven calendar days.

_____ **ELECTION 3**

When I lose time from work due to this injury or illness, I hereby elect to USE THE PORTION INDICATED below of my accrued compensatory, holiday, and overtime, thereby freezing the remaining balance until I return to work. I have indicated the total amount of time in each category to use:

A. COMPENSATORY TIME	_____	HOURS/MINUTES
B. HOLIDAY TIME	_____	HOURS/MINUTES
C. OVERTIME	_____	HOURS/MINUTES

EMPLOYEE'S NAME AS SHOWN ON PAYROLL (PRINT OR TYPE)

EMPLOYEE'S SSN

DATE OF INJURY (mm/dd/yyyy)

I understand:

I cannot receive workers' compensation payments while using accrued sick leave, sick leave pool, or while on extended sick leave and vacation leave.

I shall request LWOP - Medical before my accrued leave is exhausted.

That holiday time shall be used within one year from the end of the work cycle in which the time was accrued; and compensatory time shall be used within one year from the end of the work cycle in which the time was accrued (two years for correctional staff only). If I freeze this time and it expires before I return to work, it cannot be restored.

I may not change Part B once the DWC FORM-1S, Employer's First Report of Injury or Illness has been submitted to the State Office of Risk Management until after returning to work for one full shift. Subsequent changes to Part B shall not be retroactive.

I have read the Employee's Guidelines and understand the effect this election may have on my benefits and that it shall affect any and all future occurrences of lost time as a result of this work-related injury or illness.

EMPLOYEE'S SIGNATURE

DATE

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Authorization for Release of Information
(SORM-16)

Patient _____
Last Name First Name MI

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management, and any associate, assistant, representative, agent, or employee thereof, any and all desired information, including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and drug tests, x-rays, x-ray reports, including copies thereof, pertaining to the physical and mental condition which is the basis of my workers' compensation claim. This includes not only all current and future information, but also all past medical information which is related to the injury or injuries which form the basis of my claim.

(Print name) _____

Photostatic copies of this signed authorization shall be considered valid as the original.

This is not a release of claims for damages.

DATED: _____ SIGNED: _____
(mm/dd/yyyy)

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO THAT WE
MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

THANK YOU,

STATE OFFICE *of* RISK MANAGEMENT

Form No. SORM-16 9-98

Distribution:

ORIGINAL - State Office of Risk Management
COPY - Workers' Compensation Program Area, Human Resources Division
COPY - Unit or Department Medical File
COPY - Employee

Assistance	The TDI-DWC provides an ombudsman to assist me at no cost. The ombudsman may be reached by calling 1-800-252-7031 or the local office of the TDI-DWC.
Length of Time Benefits are Available	I recognize that benefits continue only until I have reached maximum medical improvement or until 104 weeks have elapsed from the beginning date of workers' compensation disability, at which time other benefits may be available.
Offer of Outside Employment	I shall notify my TDCJ human resources representative and the State Office of Risk Management of any bona fide offer and acceptance of employment.
Employment Status	If I am receiving workers' compensation benefits, I shall notify my TDCJ human resources representative and the State Office of Risk Management within one workday of getting another job.
Receipt of Wages	I shall report any wages received after the date of injury or illness while benefits are continuing to my TDCJ human resources representative and the State Office of Risk Management.
Warning Against Misrepresentation	I understand that any misrepresentation or concealment of information concerning my claim may be a violation of federal or state law.

Human Resources Representative:

(Print)	Last Name	First Name	MI
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Title _____

(Area Code) (Telephone #)

HR Representative Signature	Date
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PERS 298-5 (09/15)

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
DWC FORM-48, “Request for Travel Reimbursement”

The TDI-DWC Rule § 134.110 provides that an injured employee may request reimbursement from the insurance carrier if the injured employee has incurred travel expenses when: (1) medical treatment for the compensable injury is not reasonably available within 30 miles from where the injured employee lives; and (2) the distance traveled to secure medical treatment is greater than 30 miles, one-way.

Employees requesting reimbursement for travel expenses shall use the DWC FORM-48, “Request for Travel Reimbursement/Solicitud De Reembolso” form.

Employees may request their human resources representative provide them with a copy of the form or print the DWC FORM-48 from the following TDI-DWC website:

<http://tdi.texas.gov/forms/dwc/dwc048trvlreim.pdf>



THE STATE OFFICE OF RISK MANAGEMENT WORKERS' COMPENSATION PRESCRIPTION INFORMATION

Employer:

Please complete the employee information below and provide the employee with this document to take with their prescriptions to any pharmacy.

Employee Name:	
Group#:	10602772
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211

Day supply is limited to 30 days for a new injury
myMatrixx Help Desk: (877) 804-4900

Employee:

The State Office of Risk Management has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:

Please obtain above information from the injured employee, if not already filled in by employer, to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

IMO MED-SELECT NETWORK®

**A Certified Texas Workers' Compensation
Health Care Network**

Employee Network Notification Packet



Workers' Compensation Network Acknowledgement Form

I have received the Notice of Network Requirements which informs me how to get health care under workers' compensation insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of physicians in the **IMO Med-Select Network®** or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my network treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I *may have to pay* the bill if I get health care from someone other than a network doctor without network approval.
5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement Form, I *am still required to use the network*.

Please fill out the following information before signing and submitting this completed Acknowledgement Form:

Name of Employer: Texas Department of Criminal Justice

SSN #: _____ **Name of Network:** IMO Med-Select Network®

Hire Date: _____ **Department:** _____

Home Address: _____
Street Address – No P.O. Box or Work Address

City State Zip Code County

Employee Signature

Date

Printed Name

Employee Phone Number



Notice of Network Requirements

Important Medical Care Information for Work-Related Injuries and Illnesses:

1. Effective September 1, 2014, your employer is partnering with IMO Med-Select Network® a certified Texas workers' compensation health care network. You are covered by the Network if you live in any of the counties listed below.
2. For any questions you may contact IMO by:
 - a. Calling IMO Med-Select Network® at 888.466.6381
 - b. Writing to P.O. Box 118577, Carrollton, TX 75011
 - c. E-mailing questions to netcare@injurymanagement.com
3. Each certified workers' compensation network must have one or more service areas where doctors and other health care workers are available to treat you if you are hurt on the job. The IMO MedSelect Network® service areas include the following counties:

Atascosa	Austin	Bandera	Bastrop
Bell	Bexar	Blanco	Brazoria
Burleson	Burnet	Caldwell	Cameron
Chambers	Colorado	Collin	Comal
Dallas	Denton	El Paso	Ellis
Fayette	Fort Bend	Galveston	Gonzales
Grayson	Guadalupe	Harris	Hays
Henderson	Hidalgo	Hill	Hood
Hunt	Johnson	Karnes	Kaufman
Kendall	Lee	Liberty	Medina
Montgomery	Navarro	Parker	Rains
Rockwall	San Jacinto	Smith	Starr
Tarrant	Travis	Van Zandt	Waller
Washington	Wharton	Williamson	Wilson
Wise	Wood		

4. A map of the service area with the above counties can also be viewed on the IMO website at www.injurymanagement.com or on page 9 of this packet.
5. Except for emergencies, if you are hurt at work and live in the network service area, you must choose a treating doctor from the list of network doctors. All services and referrals are to be received from your treating doctor.
6. You have the right to select your HMO primary care physician (PCP) as your treating doctor if your HMO PCP was selected prior to your injury at work. The network prefers that you make this decision as soon as possible. Your HMO PCP must agree to abide by the workers' compensation health care network's contract and rules.
7. Except for emergencies, the network must arrange for services, including referrals to specialists, to be accessible to you on a timely basis and within the time appropriate to the circumstances and your condition, but no later than 21 days after the date of the request.
8. If you need emergency care, you may go anywhere. If you become injured after business hours and it is not an emergency, go to the closest health care facility.
9. If you cannot contact your treating doctor after business hours, and you are in need of urgent care, go to the closest urgent care facility.
10. If you do not live in a network service area, you are not required to receive care from network providers.
11. If you are hurt at work and you do not believe you live within the network service area, call the State Office of Risk Management (SORM) at 877.445.0006. SORM must review the information within seven calendar days and notify you of their decision in writing.
12. SORM may agree that you do not live in the network service area. If you receive care from an out-of-network provider, and it is later determined that you live in the network service area, you may be required to pay the bill for health care services.
13. If you disagree with SORM's decision in regards to the network service area, you may file a complaint with the Texas Department of Insurance. Complaint form information is addressed in #27.
14. Even if you believe you do not live in the network service area, you still may receive health care from network doctors and other network health care staff while your complaint is reviewed by SORM and the Texas Department of Insurance.

15. SORM will pay for services provided by the network treating doctor and other network health care providers. Except for emergency care, you may be required to pay the bill if you get care from someone other than a network doctor without approval.
16. All network doctors and other providers will bill SORM for medical services related to your compensable work injury. The employee should not be billed by the network provider. Unless there is an emergency need, the network must approve any of the following health care services before they are provided to you:
 - a. Admission to a hospital
 - b. Physical therapy/occupational therapy, beyond allowable sessions
 - c. Chiropractic care, beyond allowable sessions
 - d. Any type of surgery
 - e. Some initial and repeat diagnostic testing
 - f. Certain injections
 - g. All work hardening or work conditioning programs
 - h. Equipment that costs more than \$1,000
 - i. Any investigational or experimental services or devices
 - j. Any treatment, service, medication, diagnostic test, or durable medical equipment that falls outside of, or not recommended by, any one of the following Evidence Based Guidelines: i) Official Disability Guidelines; ii) American College of Occupational and Environmental Medicine; iii) Medical Disability Advisor
 - k. Mental health care
 - l. All chronic pain programs
17. “Adverse Determination” means a determination, made through utilization review or retrospective review, that the health care services furnished or proposed to be furnished to an employee are *not* medically necessary or appropriate.
18. If the proposed health care services are for concurrent hospitalization, the person performing utilization review must, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are pre-authorized. For all other requests for preauthorization, the person performing utilization review must issue and transmit the determination no later than three business days after the date the request is received.
19. If the network issues an adverse determination of the request for health care services, you, a person acting on your behalf, or your doctor may file a request for reconsideration by writing a letter or calling the network. Even though you can request a reconsideration of the denial yourself, the network encourages you to talk to your doctor about *filing* the reconsideration. He or she may have to send medical information to the network. This reconsideration must be submitted within 30 days of the date that your doctor receives the adverse determination in writing.

20. The network will respond to the reconsideration request within five business days of receipt demonstrating that the network has received the information. The network has up to 30 business days for the final determination. If it is a reconsideration request for concurrent review, the network will respond within three business days. The network will respond within one business day if it is a reconsideration request which involves a denial of proposed health care services involving post-stabilization treatment, life-threatening conditions or for continued length of stay in a facility.
21. Independent Review Organization (IRO) exemption: An employee with a life-threatening condition is entitled to an immediate review by an IRO and is *not* required to comply with the procedures for a reconsideration of an adverse determination.
22. If the network renders an adverse determination on a reconsideration of the following: i) a preauthorization review, ii) a concurrent review or iii) a retrospective review, the notification will include information on how to request an IRO. Requests for an IRO must be sent no later than 45 days from the date of the denial of the reconsideration.
23. If the situation is life threatening, you do not have to go through the network reconsideration process. You, the person acting on your behalf, or the requesting provider may request a review by an IRO. IRO requests shall be made to the Texas Department of Insurance on behalf of the patient by the Utilization Review Agent (URA).
24. An IRO review may be requested for several other reasons besides a life-threatening situation. The reasons may include: i) if the network denies the health care a second time by denying your reconsideration; ii) if the network denies the referral made by your treating doctor because it is not medically necessary; or iii) if the network denies your care because it is not within treatment guidelines.
25. After the review by the IRO, they will send a letter explaining their decisions. SORM will pay the IRO fees.
26. Your treating doctor may decide to leave the network. If so, and if it may harm you to immediately stop the doctor's care, SORM must pay your treating doctor for up to 90 days of continued care.
27. If you are dissatisfied with any part of the network, you can file a complaint. Any complaint must be filed within 90 days of the event with which you are dissatisfied. When a complaint is received, you will be sent a notification letter within seven days, which will describe the complaint procedures. The network will review and resolve the complaint within 30 days of receipt. *You can contact the network by:*

- a. Calling: 877.870.0638
- b. Writing: IMO Med-Select Network®
Attention: NetComplaint Dept.
P.O. Box 118577
Carrollton, TX 75011
- c. E-mailing: netcomplaint@injurymanagement.com

28. The network will not retaliate if:

- a. An employee or employer files a complaint against the network, or appeals a decision of the network, or
- b. A provider, on behalf of the employee, files a complaint against the network or appeals a decision of the network.

29. If you file a complaint with the network and are dissatisfied with the network resolution, you may file an appeal with the Texas Department of Insurance (TDI). *You can receive a complaint form from:*

- a. The TDI website at www.tdi.texas.gov, or
- b. Write to TDI at the following address:
Texas Department of Insurance
HMO Division, Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104


30. Within five business days, the network will send a letter confirming they received the appeal.

31. A list of network providers will be updated every three months, including:

- a. The names and addresses of network providers grouped by specialty. Treating doctors shall be identified and listed separately from specialists; and
- b. Providers who are authorized to assess maximum medical improvement and render impairment ratings shall be clearly identified.

32. You can view, print, or email a provider directory online at www.injurymanagement.com.

Fold here




Attention Participating Network Employee

- Show this card to each and every medical provider that treats you for your work-related injury.
- With the exception of emergency medical care, you must treat with a network provider.
- This card is for information purposes only and does not guarantee coverage.

Please contact IMO at 888.466.6381 with any questions.

WORKERS' COMPENSATION IDENTIFICATION CARD





FOR WORKERS' COMPENSATION HEALTH CARE NETWORK ONLY

Attention Provider

- With the exception of emergency and initial medical treatment, you are required to notify the network of all referrals.
- You must also be an approved network provider.
- Contact the IMO Med-Select Network® to verify if you are an approved provider, or with questions regarding medical services.

IMO Contact Information:
Phone: 888.466.6381, Fax: 877.946.6638
Email: netcare@injurymanagement.com

Send Medical Bill to:
State Office of Risk Management, PO Box 13777, Austin, TX 78711

Cut here



IMO MED-SELECT NETWORK®

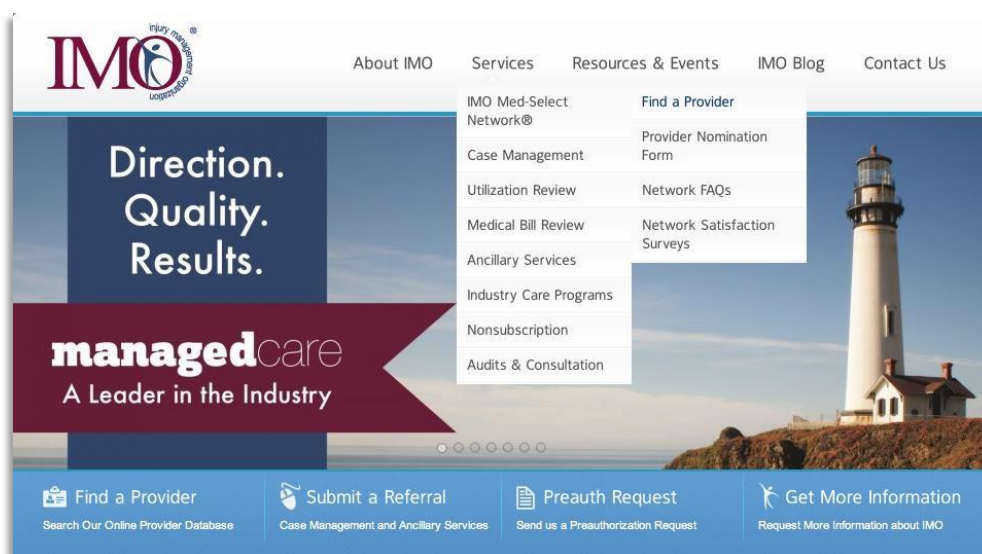
Service Area Map

Dallam	Sherman	Hansford	Lipscomb
Hartley	Moore	Hutchinson	Roberts
Oldham	Potter	Carson	Gray
Deaf Smith	Randall	Armstrong	Donley
			Collingsworth
Parmer	Castro	Swisher	Briscoe
			Hall
			Childress
Bailey	Lamb	Hale	Hoyd
			Motley
Cochran	Hodgley	Lubbock	Crosby
			Dickens
Yoakum	Terry	Lynn	Gairza
			Kent
			Stonewall
Gaines	Dawson	Borden	Scurry
			Fisher
Andrews	Marin	Howard	Mitchell
			Nolan
			Taylor
			Callahan
			Eastland
			Erath
			Schmeling
			Hood
			Johnson
			Ellis
			Navarro
			Hill
			Resque
			McLennan
			Freestone
			Anderson
			Cherokee
			Rusk
			Panola
			Gregg
			Harrison
			Marion
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			Franklin
			Titus
			Hopkins
			Gandy
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			Grayson
			Cooke
			Monterey
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			Wichita
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			Hardeman
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			Archer
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			Rockwall
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			Knox
			Bayler
			Archer



Find a Provider Search Instructions www.injurymanagement.com

The snapshots below show samples of the following: **1)** A visual of the website homepage where the “Find a Provider” search can be easily located on the blue bar across the middle or under the “Services” tab; **2)** A visual of the page where the “Find a Provider” search and database are located; **3)** Step 1 and 2 of the search process; **4)** Search results format based on a sample zip code.



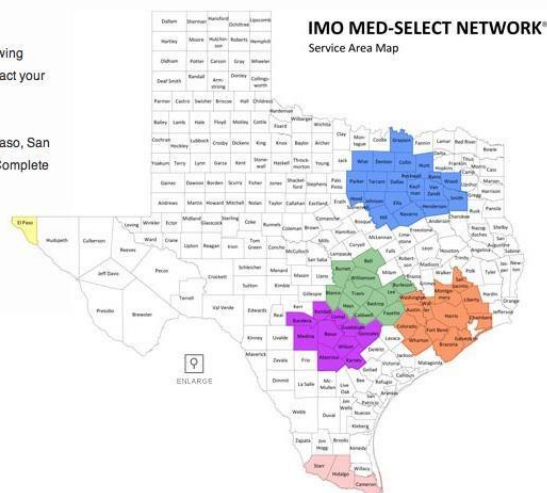
Getting Started

Determine Your Service Area

The service areas in the IMO Med-Select Network® include the following counties. If you **do not** live in a geographic county listed, please contact your employer or IMO at 877.772.4477 Ext. 151 for further assistance.

Main service areas include Austin, Dallas / Fort Worth, Houston, El Paso, San Antonio and the Valley. Finding the right provider near you is easy! Complete Steps 1 and 2 below and click submit.

IMO Med-Select Network®			
Austin	Houston	North Texas	San Antonio
Bastrop	Austin*	Collin	Kaufman
Bell	Brazoria	Dallas	Navarro*
Blanco*	Chambers	Denton	Parker
Burleson*	Colorado*	Ellis	Rains*
Burnet*	Fort Bend	Grayson	Rockwall
Caldwell	Galveston	Henderson	Smith
Fayette*	Harris	Hill*	Tarrant
Hays	Liberty	Hood	Van Zandt*
Lee*	Montgomery	Hunt	Wise
Travis	San Jacinto*	Johnson	Wood*
Williamson	Waller		
El Paso	Washington*		
El Paso	Wharton*		
*Rural Counties			



Step 1: Define Your Search

One or more of the following can be used to define your search.

Define Your Search

Enter Your Zip Code: *To search by multiple zip codes, insert a comma OR space in between each.*

Tell us Your Preferred Distance: ☐ Less than 5 Miles ☒ 15 Miles ☐ 30 Miles ☐ 60 Miles ☐ 75 Miles

Search by Practice / Facility Name: Search by Provider Tax ID Number:

Search by Provider Last Name: Search by City Name:

Step 2: Choose Your Provider Type

Select the provider type you want to search and use the dropdown menus to best narrow your criteria.

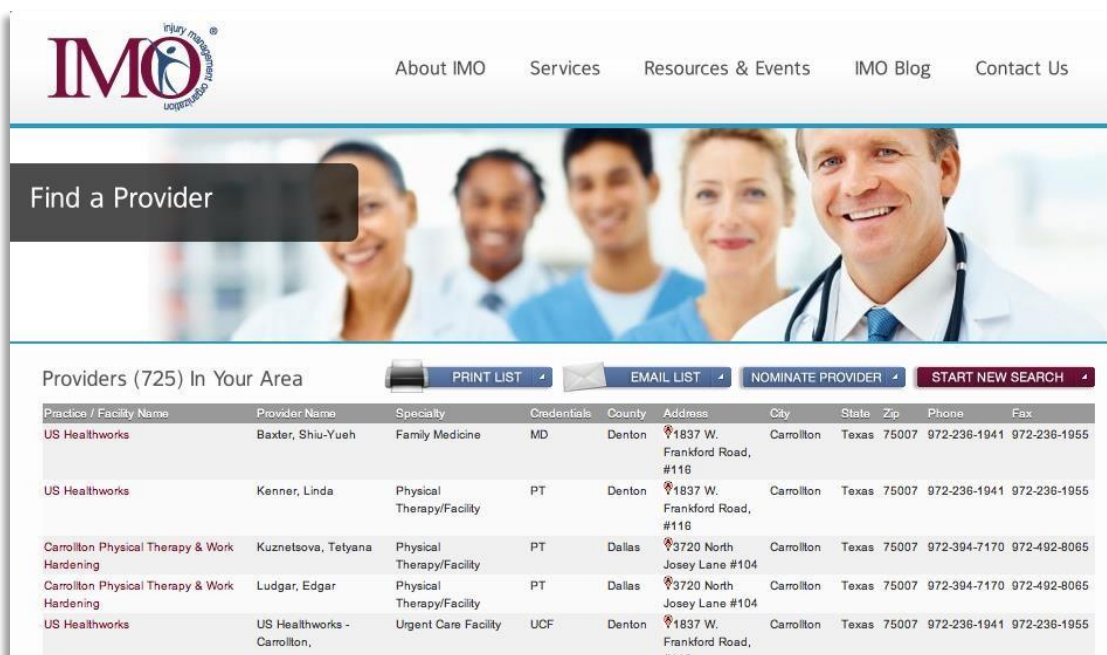
Choose Your Provider Type

<input checked="" type="radio"/>	Treating Doctors	<p>The IMO Med-Select Network® requires your <i>treating doctor</i> to be a physician chosen from the network directory and who is a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO). Treating doctors' primary service <i>must</i> be one of the following: Family Practice / Family Medicine, General Practice / General Medicine, Occupational Medicine, Internal Medicine or Physical Medicine & Rehabilitation (in El Paso only).</p> <p><input type="text" value="Select Treating"/></p>
<input type="radio"/>	Specialists / Facilities	<p>Your treating doctor must be the one to refer you to a specialist.</p> <p><input type="text" value="Select Specialty"/></p>
<input type="radio"/>	MMI / IR Physicians	<p>Your treating doctor must be the one to refer you to a Maximum Medical Improvement and / or an Impairment Rating Physician.</p>
<input type="radio"/>	All Providers	<p>Your treating doctor must be the one to refer you to a Maximum Medical Improvement, Impairment Rating Physician or Specialist.</p>

Review Search Results

After Steps 1 and 2 are submitted, you will see the below information shown in this sample snapshot including the option to print and email the list, in addition to Google Map directions if desired.

To view the **“Provider Details”** page, click on the **“Practice / Facility Name”** in red you wish to see.



The screenshot shows the IMO Med-Select Network website. At the top is the IMO logo and navigation links: About IMO, Services, Resources & Events, IMO Blog, and Contact Us. Below the navigation is a banner image of healthcare professionals with a 'Find a Provider' button. The main content area displays 'Providers (725) In Your Area' with buttons for 'PRINT LIST', 'EMAIL LIST', 'NOMINATE PROVIDER', and 'START NEW SEARCH'. A table lists several providers with their details.

Practice / Facility Name	Provider Name	Specialty	Credentials	County	Address	City	State	Zip	Phone	Fax
US Healthworks	Baxter, Shiu-Yueh	Family Medicine	MD	Denton	1837 W. Frankford Road, #116	Carrollton	Texas	75007	972-236-1941	972-236-1955
US Healthworks	Kenner, Linda	Physical Therapy/Facility	PT	Denton	1837 W. Frankford Road, #116	Carrollton	Texas	75007	972-236-1941	972-236-1955
Carrollton Physical Therapy & Work Hardening	Kuznetsova, Tetyana	Physical Therapy/Facility	PT	Dallas	3720 North Josey Lane #104	Carrollton	Texas	75007	972-394-7170	972-492-8065
Carrollton Physical Therapy & Work Hardening	Ludgar, Edgar	Physical Therapy/Facility	PT	Dallas	3720 North Josey Lane #104	Carrollton	Texas	75007	972-394-7170	972-492-8065
US Healthworks	US Healthworks - Carrollton,	Urgent Care Facility	UCF	Denton	1837 W. Frankford Road, #116	Carrollton	Texas	75007	972-236-1941	972-236-1955

For further questions, please contact the IMO Med-Select Network® at 888.466.6381.



IMO Med-Select Network® Frequently Asked Questions

1. What is a certified Texas workers' compensation health care network?

It is a program that has been certified by the State of Texas to provide health care services to you if you become injured at work.

2. What is Injury Management Organization, Inc. (IMO)?

IMO is a Certified Utilization Review Agent (URA) and the parent company to the IMO Med-Select Network®. IMO provides Case Management, Preauthorization, Medical Bill Review, Industry Care Programs, along with other health care management services.

3. How do I find out more about the IMO Med-Select Network®?

- Visit website at www.injurymanagement.com
- Write to: IMO Med-Select Network®, P.O. Box 118577, Carrollton, TX 75011
- Call the Network Main Line: 214.217.5939 or 888.466.6381
- Call the Customer Care Line: 214.217.5936 or 877.870.0638

4. What is a service area?

A service area is any county where the network operates with physicians and other health care providers to care for injured employees. If the network lists a county as part of its service area there will be providers for all zip codes in that county ready to provide health care services to the injured employees. If you live in a county covered by a service area, you are required to use a network provider.

5. What should I do if I move to a different zip code?

Notify your employer immediately to assist them in making sure that the network has service area coverage for you.

6. May I use a P.O. Box for my official address when I participate in the network?

No. The network requires a physical address in order to ensure all communication reaches the injured employee.

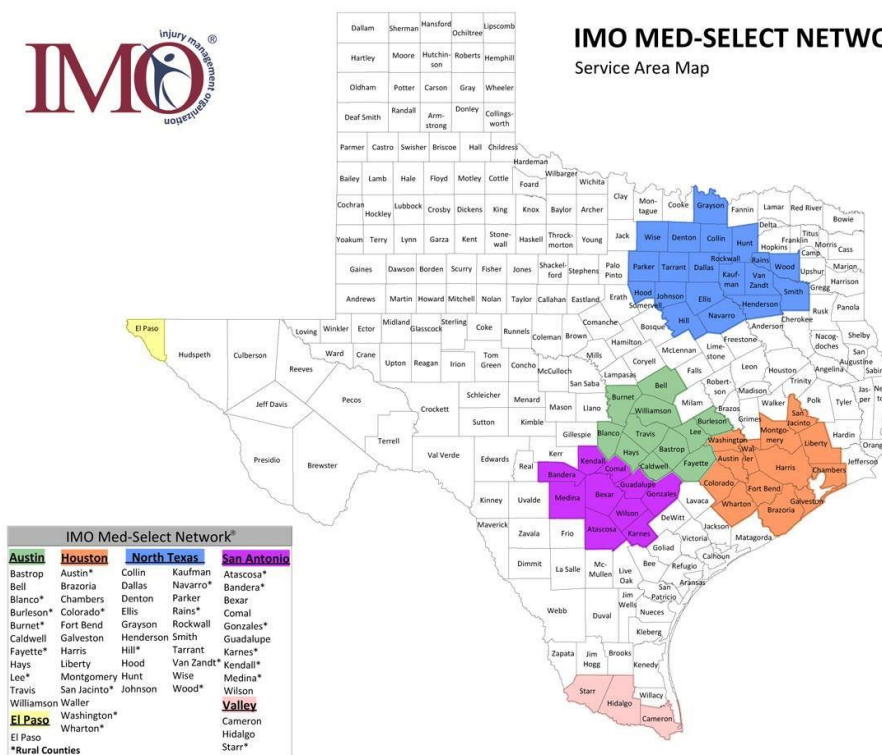
7. Where does the network operate?

The network operates in the following counties or service areas:

Atascosa	Austin	Bandera	Bastrop
Bell	Bexar	Blanco	Brazoria
Burleson	Burnet	Caldwell	Cameron
Chambers	Colorado	Collin	Comal
Dallas	Denton	El Paso	Ellis
Fayette	Fort Bend	Galveston	Gonzales
Grayson	Guadalupe	Harris	Hays
Henderson	Hidalgo	Hill	Hood
Hunt	Johnson	Karnes	Kaufman
Kendall	Lee	Liberty	Medina
Montgomery	Navarro	Parker	Rains
Rockwall	San Jacinto	Smith	Starr
Tarrant	Travis	Van Zandt	Waller
Washington	Wharton	Williamson	Wilson
Wise	Wood		



IMO MED-SELECT NETWORK®
Service Area Map



8. Form Requirements

- a. Will I need to sign any forms? Your employer will provide you with a Notice of Network Requirements and an Acknowledgement Form. You will also be presented with an Acknowledgement Form for signature at the time of injury.
- b. What will happen if I choose not to sign the Acknowledgement Form? If you refuse to sign the Acknowledgement Form, you are still required to participate in the network.

9. Who is responsible for paying for my medical care if I receive treatment outside of the network?

If you receive care from an out-of-network provider, you *may* be financially responsible for the health care services if it is determined that you live in the network service area.

10. Who can be a network treating doctor?

The IMO Med-Select Network® requires your treating doctor to be a physician chosen from the network directory who is a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO). The treating doctor must be a specialist in Family Practice, General Practice, Internal Medicine or Occupational Medicine; in El Paso, TX, your treating doctor may hold any of the above listed specialties or be a specialist in Physical Medicine Rehabilitation.

11. How do I choose my treating doctor?

After an injury occurs, you must choose your treating doctor from the network provider list. If you need help, you may call a network customer care representative for assistance at 888.466.6381 Monday-Friday 8-5 p.m. CST or online at www.injurymanagement.com and click "Find a Provider." If your injury requires emergency care, you may be treated in any emergency care facility.

12. May I select my HMO primary care doctor for my network treating doctor?

As a State of Texas employee, you have a choice of group health insurance plan. Not all of them are HMO plans. If you are covered by an HMO plan, and have already selected a primary care doctor, **prior to your injury**, you may request to choose your HMO primary care doctor as your workers' compensation treating doctor. This can be done by completing the Network Form # IMO MSN-5. To obtain this form, please contact the IMO Med-Select Network® at 888.466.6381 or email netcare@injurymanagement.com. The network will contact your HMO doctor to participate in the network. If your doctor does not agree or does not meet the certified network qualification requirements to participate in the network you must choose a treating doctor from the network list.

If you are uncertain of whether you are covered by an HMO plan, please contact the appropriate human resources representative for clarification.

13. How do I nominate a doctor?

- a. The IMO Med-Select Network® is pleased to receive nominations to add providers to our network. The first step is to fill out a nomination form available on the IMO website at www.injurymanagement.com or by contacting SORM. The network has a nomination form and credentialing process that must be completed prior to any doctor being considered as a network provider.
- b. The network will contact your doctor about participating in the network. If your doctor does not agree *or* does not meet the certified network qualification requirements, you must choose another treating doctor from the network list.

14. Am I required to see a doctor close to my residence?

Although the network must provide you with access to a treating doctor within a 30-mile radius of your residence, you can choose any treating doctor on the list of treating doctors in the network.

15. Can my chiropractor or my orthopedic surgeon be my treating doctor?

No, the treating doctor must be a specialist in Family Practice, General Practice, Internal Medicine, or Occupational Medicine; in El Paso, TX, all specialists listed above or Physical Medicine Rehabilitation. For treatment by any other type of specialist, including a chiropractor or orthopedic surgeon, you must be referred by your treating doctor.

16. Do you have physician assistants or nurse practitioners in the certified network?

No, the certified network does not have physician assistants or nurse practitioners contracted to treat injured employees at this time. You may be treated by one of the above if it is under the direction of a medical doctor in the certified network.

17. Can I change my treating doctor?

You are limited to the changes you can make. These limits are set to ensure that you have quality and continuity in your care.

- a. Change #1 is called the alternate choice. When you contact the network you will be asked to complete the **Request for Alternate Treating Doctor Form # IMO MSN-1**. The network will not deny your request for your selection of an alternate choice.
- b. Change #2 is called your subsequent change. If you have used your alternate choice of treating doctor and you are still dissatisfied, you must request and receive permission from the network for the subsequent change of treating doctor.

You will need to contact the network at:

- Telephone: 214.217.5939 or toll free 888.466.6381
- E-mail: netcare@injurymanagement.com or,
- By faxing the completed form to 214.217.5937 or 877.946.6638
 - You may also mail a copy of the **Request For Subsequent Change in Treating Doctor Form # IMO MSN-7** to: IMO Med-Select Network®, P.O. Box 118577, Carrollton, TX 75011
- Complaints: netcomplaint@injurymanagement.com

18. What do I do if my treating doctor dies, retires, or leaves the network?

If your current treating doctor dies, retires, or leaves the network you are allowed a change of treating doctor at any time during your care.

19. What if I don't live in the service area?

If you do not live in the service area, you are not required to receive health care from the certified network. You should contact your Claims Coordinator or SORM to discuss this matter.

20. The Notice of Network Requirements states that I must receive medical care from the network if I live in the network service area. How is "live" defined?

Where an employee lives includes:

- a. The employee's principal residence for legal purposes, including the physical address which the employee represented to the employer as the employee's address;
- b. A temporary residence necessitated by employment; or
- c. A temporary residence taken by the employee primarily for the purpose of receiving assistance with routine daily activities because of the compensable injury.

28 Texas Administrative Code §10.2(a) (14)

21. What if I need to be referred to a specialist?

If you need a specialist, your treating doctor will refer you. You must go to a health care provider in the network, except in emergencies and other special circumstances. All referrals to a specialist must be approved by your treating doctor. Appointments with specialists are to be set no later than 21 days after the date of the request. If there is an urgent medical need, a shorter time period may be appropriate.

22. What if I need a specialist that is not in the network?

If your treating doctor decides there is no provider or facility in the network that can provide the treatment you need for your compensable injury, he or she will contact the network for permission to send you to a provider outside of the network.

Your treating doctor is required to submit to the network a completed referral called a **Request for Out-of-Network Specialist Form # IMO MSN-4**. The network will approve or deny the request within seven days of receiving this form from the treating doctor.

You and your treating doctor will be notified by telephone and in writing if the request is not approved. The notice will also explain the appeal process.

23. What is Telephonic Case Management?

When you are injured at work you may be provided with a Telephonic Case Manager (TCM) to assist with coordination of your medical needs. A TCM is a licensed and certified medical professional that will help coordinate the medical services that your doctor recommends. The TCM will also provide education and help with communication between you and your doctor and employer. The network wants you to have the best quality of care and a safe stay-at-work /return-to-work health outcome.

24. What is considered to be an emergency?

As defined by the Texas Insurance Code:

“Medical Emergency” means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

- a. Placing the patient’s health or bodily functions in serious jeopardy; or
- b. Serious dysfunction of any body part or organ.

25. How do I receive emergency care?

You should seek treatment from the nearest urgent care facility or hospital emergency room if emergency care is necessary. The network provider directory lists urgent care centers and hospitals that participate in the network.

26. How can I get a network provider directory?

Your employer will have a network provider directory available. A network provider directory also will be available at:

- a. IMO website: www.injurymanagement.com
- b. Or you may call us directly at:
 - Network Main Line – 214.217.5939 or 888.466.6381
 - Customer Care – 214.217.5936 or 877.870.0638

27. Will medical services need prior approval?

Some medical services must be approved in advance. Unless there is an emergency need, your treating doctor must contact the network for approval prior to providing the following health care services:

IMO Network Preauthorization List

a. *Hospital and Surgical Care*

- Inpatient admissions including length of stay and, when necessary, extending the authorized length of stay
- Inpatient and outpatient surgical procedures performed in hospital or Ambulatory Surgical Center (ASC) setting

b. *Mental Health Care*

- All psychological/psychiatric services after the initial evaluation/testing

c. *Physical Medicine Services (regardless of location)*

- Osteopathic or chiropractic manipulations after two weeks of services
- Physical or occupational therapy outside of the first nine sessions occurring within the first 30 days following the initial treatment date or up to 12 sessions occurring within 60 days following surgical intervention

d. *Diagnostic Testing*

- CT myelograms and discogram CTs
- Repeat diagnostics

e. *Injections*

- Epidural Steroid Injections (ESI's) and Facet Injections
- Medial Branch Blocks and Rhizotomies

f. *Rehabilitation Programs*

- Work hardening, work conditioning, and outpatient rehabilitation regardless of accreditation
- Pain management, chemical dependency, and weight loss

g. *Durable Medical Equipment (DME):* Billed at \$1,000 or greater per item, either cumulative rental or purchased. All electrical and/or neuromuscular stimulators including transcutaneous electrical stimulators (TENS) or interferential stimulators

h. *Treatment not addressed or not recommended by Evidence Based Guidelines:* Unless preapproved as part of a treatment plan

28. What happens if I am unable to work?

Your Telephonic Case Manager will work with your doctor, employer, and adjuster to coordinate possible work programs to accommodate your restrictions while rehabilitating.

29. How do I file a complaint?

- a. If you are dissatisfied with any aspect of the network, you may file a complaint by completing the **Complaint Form # IMO MSN-3**.
- b. You must file the complaint within 90 days of the event about which you are dissatisfied.
- c. To obtain and submit this form you can contact the **Network Complaint Dept.** by:
 - Writing: P.O. Box 118577, Carrollton, TX 75011
 - Calling: 877.870.0638
 - E-mailing: netcomplaint@injurymanagement.com
- d. The network will respond to your complaint with a letter of acknowledgment within seven calendar days after receipt of the complaint.
- e. Every complaint will be investigated and resolved within 30 calendar days after receipt of the complaint.
- f. The network will send a letter to you explaining its decision and recommendations.

30. How do I file an appeal?

- a. If you are dissatisfied with the complaint response, you must submit your appeal either by calling the network at 877.870.0638 or writing to the network. This process does not require a form completion, but you may use the **Complaint Form # IMO MSN-3** and check the appropriate box to indicate that you are filing an appeal:

IMO Med-Select Network® Attention:
NetAppeal Committee
P.O. Box 118577
Carrollton, TX 75011

- b. File the appeal within 15 days of receiving the decision letter.
- c. The network will send a letter when it receives the appeal and once again when the decision is made.

31. What should I do next, if I do not agree with the network's complaint or appeal resolution?

If you are dissatisfied with the network's complaint or appeal resolution, you may file a complaint with the Texas Department of Insurance (TDI). A complaint form can be accessed at:

- a. TDI website at www.tdi.texas.gov, or
- b. TDI HMO Division at the following address: HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
DWC FORM-73 Notification

Beginning May 1, 2006, health care providers must use the DWC FORM-73, "Texas Workers' Compensation Work Status Report," which replaced the TWCC FORM-73, "Texas Workers' Compensation Work Status Report."

The new form may be obtained from the following TDI-DWC Texas Department of Insurance, Division of Workers' Compensation forms webpage:

<http://www.tdi.texas.gov/forms/dwc/dwc073wkstat.pdf>

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Supervisor's Report Packet for Workers' Compensation

CONTENTS

PERS 299-1, Supervisor's Guidelines for Workers' Compensation

PERS 299-2, Witness Statement

PERS 299-3, Supplemental Worksheet

TEXAS DEPARTMENT OF CRIMINAL JUSTICE Supervisor's Guidelines for Workers' Compensation

Do not delay emergency medical treatment pending completion of packet!

- ◆ **Maintain an ample supply of Employee's and Supervisor's Report Packets.**
- ◆ **If an employee was involved in a work-related incident that could have exposed them to a communicable disease, immediately: (1) have the employee complete a PERS 298, Employee's Report Packet for Workers' Compensation and a PERS 305, Possible Work-Related Exposure to a Communicable Disease (Attachment A); and (2) send the employee to the CID nurse for baseline testing. If the employee refuses to go for baseline testing, have the employee sign a statement reflecting that decision.**
- ◆ **Distribute a PERS 298 packet and an applicable job description to any employee who sustains a work-related injury or illness. You may obtain the job description from the human resources representative. Employees shall complete and submit their packets to you during the same shift the injury or illness occurs.**

Ensure the employee reviews the PERS 298 packet and understands the impact the C-80 election form shall have on the employee's monthly paycheck and other benefits before you sign Part B of the PERS 298-2, Employee's Report of Injury or Illness.

If the work-related injury or illness has rendered the employee unable to complete the packet and the employee did not designate someone to act on the employee's behalf, you shall act as the designee, complete the PERS 298-2, Part A and Part B, and submit it to the human resources representative during the same shift the injury or illness occurs.

- ◆ **Remove the DWC FORM-48, "Request for Travel Reimbursement" and provide the notification to the employee for possible future use.**
- ◆ **Audit Employee's Packet for the following:**

PERS 298-2 - Employee's Report of Injury or Illness

- ☒ Form is submitted during the same shift the incident occurred.
- ☒ Each section in Part A is completed
- ☒ Employee signed and dated the form

PERS 298-3 - Employee's Election Regarding Use of Sick and Vacation Leave (C-80 Form)

- ☒ Employee has chosen an election in each part, A and B, and signed and dated the form

PERS 298-4 - Authorization for Release of Information (SORM-16 Form)

- ☒ Form is completed, signed, and dated

- ◆ **Coordinate with the human resources representative to determine whether or not the employee is qualified for FML and follow guidelines in the appropriate directive.**
- ◆ **Complete the Supervisor's Packet during the same shift the injury or illness occurs.**

The human resources representative should be able to answer any questions you may have about completing any form in the packet. The following information may help you complete the forms.

PERS 298-2, Employee's Report of Injury or Illness

Complete Part B, Supervisor Acknowledgement of Injury or Illness. Coordinate with the human resources representative to ensure that the sick leave balance on the date of injury is correctly calculated by taking into consideration any sick leave used since the last update to the time screen.

PERS 299-2, Witness Statement

You shall obtain a witness statement from each witness the employee indicated. If the employee listed an offender as a witness, the offender's TDCJ number shall be noted on the PERS 298-2. Do not delay in submitting report packets to the human resources representative because you have not received applicable witness statements. Submit the packet without them and follow up on the statements as soon as possible.

◆ Submit the Employee packet to the human resources representative.

Submit witness statements, if applicable, along with the employee's PERS 298 packet to the human resources representative during the same shift the injury or illness occurs.

- You are not relieved of reporting responsibility even if the employee fails to furnish a completed Employee's Packet.

Verify the completeness of the Employee Packet and the Supervisor Packet by comparing each form with those listed on the Contents page of each packet (the top page of each packet).

◆ If the employee has not notified the human resources representative of the employee's change in status, submit a PERS 299-3, Supplemental Worksheet, to the human resources representative during the same shift of occurrence that the employee:

- Returns to full duty after being absent due to the work-related injury or illness. Prior to performing job duties, the employee must submit a DWC FORM-73, Texas Workers' Compensation Work Status Report, or a health care provider's statement releasing the employee to full duty without restrictions if the employee was absent for more than three consecutive workdays or the release indicates restrictions;
- Requires additional days off due to the initial work-related injury or illness. The date is the first full shift of lost time after the employee's latest return to work;
- Is called to service in the uniformed services while on leave without pay;
- Resigns or is separated from employment; or
- Dies.

You are responsible for notifying the human resources representative by the end of the shift of any changes to the employee's status that occur after the initial submission of the Supplemental Worksheet.

◆ Coordinate with the human resources representative to ensure employee leaves are managed in accordance with applicable TDCJ policies and to ensure qualified absences are appropriately designated as FML.

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Witness Statement
(Please print or type)

Injured Employee's Full Name: _____ Date of Injury: _____

OFFENDERS – COMPLETE THIS SECTION

Name: _____ Age: _____
Last Name First Name MI
Unit or Location: _____ TDCJ #: _____

ALL OTHER WITNESSES – COMPLETE THIS SECTION

Name: _____ Age: _____
Last Name First Name MI
Address: _____
Street Address City State Zip Code
SSN: _____ Home Phone: () _____ Work Phone: () _____

I am an employee of: _____ Unit or Department.

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Tex. Gov't Code §§ 552.021 and 552.023, to receive and review the collected information. Under Tex. Gov't Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

ALL WITNESSES - COMPLETE THE FOLLOWING

On _____ at about _____ (Circle One) AM or PM I was (clearly state your exact location
Date (mm/dd/yyyy) Time
at the time of the alleged accident) _____

When an accident involving the above employee is alleged to have occurred.

CHECK APPLICABLE BOX:

☐ I observed the accident and it occurred in the following manner: _____

Other pertinent information and source: _____

☐ I did not observe the accident; however, information given to me by (injured employee or witness) indicates it occurred as follows: _____

Other pertinent information and source: _____

☐ I have no knowledge of the occurrence.

Signature _____ Date (mm/dd/yyyy) _____

Complete and return this form to the supervisor **within one workday**.

Distribution:

Reportable: ORIGINAL - State Office of Risk Management
COPY - Workers' Compensation Program Area, Human Resources Division
COPY - Unit or Department Medical File
COPY - Employee

Not Reportable: ORIGINAL - Unit or Department Medical File
COPY - Employee

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Supplemental Worksheet
Change in Employee's Leave Status Relating to a Work-Related Injury

Name of Injured: _____ SSN: _____
Last First MI
Unit or
Department: _____ HR Region: _____ Date of Injury: _____
(mm/dd/yyyy)

CHECK APPLICABLE BOX FOR CHANGE IN STATUS:

- ☐ Returned to Work on: _____ (Date of First Full Shift Employee Returned to Work)
(mm/dd/yyyy)
☐ Full Duty or ☐ Temporary Alternate or Modified Duty
- ☐ Accepted or rejected offer of temporary alternate or modified duty on: _____
(mm/dd/yyyy)
- ☐ Additional days of workers' compensation disability beginning: _____ (Date of First Full Shift of Lost Time Due to the Injury)
(mm/dd/yyyy)
- ☐ Exhausted sick/vacation leave balance on: _____ (Only required if employee chose C-80 Part A, Election 1.)
(mm/dd/yyyy)
- ☐ Placed on extended sick leave with pay beginning: _____ through _____
(mm/dd/yyyy) (mm/dd/yyyy)
- ☐ Placed on sick leave pool beginning: _____ through _____
(mm/dd/yyyy) (mm/dd/yyyy)
- ☐ Placed on: ☐ leave without pay (LWOP) workers' compensation or ☐ LWOP-FML beginning: _____
(mm/dd/yyyy)

PERS 301, Notification of Medical and Family Leave sent on: _____
(mm/dd/yyyy)

- ☐ Change in approved LWOP status

FML exhausted on: _____
(mm/dd/yyyy)

Placed on LWOP workers' compensation on: _____
(mm/dd/yyyy)

Placed on active payroll to run vacation leave on: _____
(mm/dd/yyyy)

- ☐ Resignation or separation effective: _____ Reason: _____
(mm/dd/yyyy)

- ☐ Death: _____
(mm/dd/yyyy)

If report is being submitted more than one workday after the change in status, provide a reason for late reporting: _____

SUPERVISOR (if applicable):

(Please Print) Last Name First Name MI Title

Signature Date: (mm/dd/yyyy)

HUMAN RESOURCES REPRESENTATIVE:

(Please Print) Last Name First Name MI Signature Date (mm/dd/yyyy)

Distribution:

ORIGINAL - Email or fax to the Workers' Compensation Program Area, Human Resources Division within one workday of change in status
COPY - Unit or Department Medical File
COPY - Risk Management Coordinator
COPY - Employee

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Return to Work Program Pooled Areas

01. PANHANDLE Amarillo Pampa Dalhart Tulia Childress Plainview	06. ABILENE AREA Abilene Breckenridge Big Spring*	12. SOUTHEAST TEXAS Beaumont Liberty Galveston Dayton Nederland* Orange* Port Arthur* Texas City
02. LUBBOCK AREA Brownfield Lamesa Colorado City Snyder Lubbock	07. PALESTINE AREA Palestine Teague Rusk Tyler* Athens*	13. HOUSTON AREA Sugar Land Richmond Rosharon Angleton Humble Rosenberg* Houston*
03. WEST TEXAS Ft. Stockton El Paso Monahans* Midland/Odessa* Del Rio* San Angelo*	08. CENTRAL TEXAS Brownwood Gatesville Marlin Burnet Austin Waco* Temple* Georgetown* San Saba	14. BEEVILLE AREA Cuero Kenedy Beeville Victoria*
04. NORTH TEXAS Wichita Falls Dallas Denton* Mineral Wells* Fort Worth* Sherman* Waxahachie* Greenville* Garland*	09. HUNTSVILLE AREA Lovelady Midway Livingston Huntsville Conroe*	15. SAN ANTONIO AREA Hondo Dilley Cotulla San Antonio Seguin*
05. NORTHEAST TEXAS Bonham New Boston Winnsboro Texarkana* Paris* Mount Pleasant* Marshall* Longview*	10. DEEP EAST TEXAS Jasper Woodville Diboll Nacogdoches*	16. SOUTH TEXAS San Diego Edinburg Laredo* McAllen* Harlingen* Corpus Christi*
	11. NAVASOTA AREA Navasota Bryan	
		*Parole Offices Only

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Offer of Temporary Alternate or Modified Duty Assignment

EMPLOYEE INFORMATION	
Name:	SSN:
Mailing Address:	Date of Injury: <small>(MM/DD/YYYY)</small>
City, State, and Zip Code:	

The Texas Department of Criminal Justice is in receipt of your Authorization to Release Medical Information and Return to Work Status Form indicating you have been released to perform a temporary alternate or modified duty assignment. The TDCJ is offering you a temporary alternate or modified duty assignment as described on the second page. This assignment shall abide by the temporary physical or mental limitations set out on the **attached** DWC FORM-73, Texas Workers' Compensation Work Status Report or health care provider's statement. **Human resources representatives shall attach one of these documents.**

- Indicate whether you accept or reject the temporary alternate or modified duty assignment on the second page of this form and return both pages of this form to the human resources representative within three workdays of receipt of this form.
- If you choose to reject the temporary alternate or modified duty assignment: (1) indicate your rejection on the second page of this form; and (2) within three workdays of receipt of this form, return both pages of this form to the human resources representative.
- Failure to respond to this offer within the specified time frame shall be considered an official rejection. The State Office of Risk Management may reduce your future workers' compensation benefits.

If you have any questions regarding the temporary alternate or modified duty assignment, job modifications, accommodations, leave entitlements, benefits, etc., contact your human resources representative.

HUMAN RESOURCES REPRESENTATIVE:

Unit or Department: _____

Printed Name: _____

Telephone No.: () _____

Signature: _____

Date: _____

FOR STATE AGENCY USE ONLY	
Initial verbal offer made <input type="checkbox"/> by phone <input type="checkbox"/> in person on _____. Verbal offer was <input type="checkbox"/> accepted <input type="checkbox"/> rejected (check one). <small style="margin-left: 350px;">(MM/DD/YYYY)</small>	
Offer sent to employee via certified mail on _____. Certified Mail Receipt No.: _____ <small style="margin-left: 300px;">(MM/DD/YYYY)</small>	
Temporary alternate or modified duty assignment begins: _____ <small style="margin-left: 350px;">(MM/DD/YYYY)</small>	
Projected expiration date (end of maximum 12 consecutive work week period): _____ <small style="margin-left: 350px;">(MM/DD/YYYY)</small>	
Employee acknowledgement of temporary alternate or modified duty assignment period: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <small>Employee Signature</small> <small>Date (MM/DD/YYYY)</small> </div>	
Temporary alternate or modified duty assignment expired: _____ <small style="margin-left: 350px;">(MM/DD/YYYY)</small>	
Reason assignment expired: <input type="checkbox"/> End of Maximum 12 Consecutive Work Week Period <input type="checkbox"/> Other: _____	
Employee acknowledgement of expiration of assignment: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <small>Employee Signature</small> <small>Date (MM/DD/YYYY)</small> </div>	

Temporary Alternate or Modified Duty Assignment Description

EMPLOYEE INFORMATION		
Name:	SSN:	Date of Injury:
(MM/DD/YYYY)		
A. Location	B. Schedule	
Unit or Department:	Work Schedule:	Card Schedule:
Address:	Work Hours: to	Hours Per Week :
	Assignment to Begin:	
Approximate Miles from Employee's Residence:	Projected Expiration Date:	
C. Wages		
\$	Monthly	Your rate of pay shall be the same as your current pay rate.

D. Duties or Tasks: You shall only be assigned tasks consistent with your physical abilities, knowledge, and skills. Training shall be provided, if necessary.

E. Maximum Physical Requirements: The following identifies the maximum physical requirements for this assignment.

Maximum Hours per day:	0	2	4	6	8	Other	Maximum Hours per day:	0	2	4	6	8	Other
Heavy lifting, 45 lbs & over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moderate lifting, 15-44 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light lifting, under 15 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heavy carrying, 45 lbs & over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moderate carrying, 15-44 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light carrying, under 15 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Straight pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulling hand over hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Climbing ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Repeated bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Use of firearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reaching above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Oper. motor equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Simple grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Oper. motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dual simultaneous grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other (Explain below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____							_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____							_____

☐ I am voluntarily **accepting** the temporary alternate or modified duty assignment offered through the Return to Work Program as described above *for a maximum period of 12 consecutive work weeks*. I fully understand the effect of accepting this assignment.

☐ I am **rejecting** the temporary duty assignment offered through the Return to Work Program as described above. I understand that as a result of rejecting the assignment, SORM may reduce my future workers' compensation benefits.

Reason for offer rejection: _____

Employee's Signature _____

Date (MM/DD/YYYY) _____

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

Distribution:

ORIGINAL - Unit or Department Employee Medical File

COPY - Employee's Supervisor

COPY - Workers' Compensation Program Area, Human Resources Division

FAX - State Office of Risk Management